Letter from Kenya

by Alison Pittendrigh LCPH(Lon) MGCP

Last year, Alison Pittendrigh returned to Kenya after a nine-year absence. In her first letter from there, published in our January issue, she wrote of her plans to set up a clinic near Mombasa and to start a teaching programme. Now her clinic and classes are up and running …

Mtwapa, Kenya January 2003

So very much has happened since I last wrote, it is difficult to know where to start! Perhaps at the beginning.

Our homeopathy clinic opened on 29 October last year, at the Harvest of Hope Community Centre. I have two rooms, one at the front of the building leading directly into another room behind it, where I see patients. I thought the front room would make a good waiting room, but realised very quickly that as the day's temperature climbed to 98°F, it was far more comfortable for patients to wait outside, in the fresh air and with some shade from the trees. I quickly invested in an ancient fan which produces just enough of a cool breeze to stop me from melting away! We already had two chairs, some rough benches and two tables to work with. A young Giriama lad also appeared on the opening day offering to help, and he has been vital in the success of the clinic. This is the 'homeland' of the Giriama people, and many of them do not speak Swahili (the language I use in consultations) very well. It's a multi-tribal area now, and this lad has been very helpful in managing the extraordinary numbers of people attending the clinic, and in translating for me when needed.

Some of the students on the course outside the classroom.

At 8 am on the first day all was quiet. I was finalising some details with the director of the community centre, and I remember being anxious that perhaps what I was trying to do was wholly inappropriate and that no-one would turn up! About 20 minutes later some patients arrived, and within the hour I had 27 waiting outside the clinic. What to do? This became the pattern for the first four weeks. I open the clinic three days a week, and every day there were similar numbers. There was, and is, no question of turning a patient away and asking them to return the next day. I thought of trying an appointment system, but that was just met with a quizzical look ('Is this *mzungu* [white person] mad?'). Very few of my patients have a watch, and time is perceived in a completely different way here. What would take a day, an hour to achieve in England takes at least a week here! The people here are blessed with an exceptional patience, and will calmly sit for hours and hours, as long as it takes. So, the only answer was to drop the time zones myself, and work with the situation. Recently the numbers have been more manageable – about 18 a day, which I find hard work but possible.

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It has been a fascinating journey. I have seen some terrible things that have tested my sensitivity to the core. Initially the faces of very ill dying children left me awake at night, the shocking sight and smell of skin conditions, the painful paralysis of patients' limbs …. I have had patients with everything you have ever heard of and more. I felt totally inadequate and aware of how much learning I continually need to do. I have often thought how very fortunate it is that I trained at the Practical College where we were given so much guidance on observing the physical and general symptoms and being able to work entirely within that framework if appropriate and/or necessary. I have had to accept that information that one takes for granted in the UK, from which one can take a 'case history', is simply not forthcoming here.

A history of past illnesses produces a 'none' response – even in patients over 50. Very few patients know how old they are, or how old their children are. I get some information if I ask if they have ever been to a doctor – that will often be a yes, but then there's the same problem: they can't remember why or when, or what the doctor said. The most common diagnosis from a visit to the doctor is that they 'don't have enough blood', which I have yet to understand. If pushed, occasionally a patient will agree that they may have had malaria once at some time, but they have no idea when. There are possibly two reasons for this: one is that you live in the 'now' here – which would explain the patience to wait as well; the other reason could be the huge fear of being diagnosed HIV positive, or of its even being suggested. In the area I am working in, it is estimated that up to 7 out of 10 people may be HIV positive. I do not enquire at this level. It would make no difference to the remedy choice anyway. I am given this information off the record by friends and family if the patient is accompanied to the clinic. 'Return of old symptoms' has to be dropped!

It's Saturday morning and the clinic is closed but these students are here for the course.

It is also quite interesting where you can go with establishing useful 'mind' symptoms. My patients find it very amusing when I ask if they have a temper. I get another quizzical questioning look: What has *that* got to do with anything?! Most of them think I am asking because I am frightened, and they reassure me that they are not going to get cross with me if that is what I am worried about! And more interestingly, asking about 'fears' elicits hoots of laughter. In the two months up to Christmas, I saw over four hundred patients, and only three responded to fear – one of evil spirits, one of snakes, and one of car accidents (she had just had one!) All of them had anxieties about how they were going to feed and clothe themselves and their families, and about their illnesses.

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The clinic is open on Mondays, Tuesdays and Thursdays. On Tuesday mornings I visit AIDS patients in their homes. They are desperately ill, pencil thin, lying on their beds in a darkened room, barely able to speak. I have had two patients who have died, which is difficult to accept. It is desperate: most, but of course not all, are vomiting all food and water (*Ipecac.* works beautifully), and I have had to teach their carers to spoonfeed water into their mouths every 10 minutes and to change their diet. Because of the extreme poverty, the staple diet is a porridge made from cornmeal, called *ugali*. AIDS patients cannot tolerate it, and I ask their carers if they can save enough money to buy some pawpaw, sweet potato, a little rice, etc., and to feed the patient with just small amounts to help get their strength up. Without some nutritious feeding, the remedies only seem to be able to hold the patient, keep them alive for a while longer. There is a great need for some kind of 'meals on wheels' set-up for these patients. For those people who have been able to find the money to offer a better diet, the patients are a little stronger every week. It is so wonderful when you visit and the patient is sitting up and engaging in the conversation, with a light in their eyes. I hope in my next letter to offer a useful case history of one of my patients.

The teaching programme has been up and running. I have ten students (and the odd cow or two that wanders in to see what is going on!) If you think how difficult it is for a lot of people in the UK to understand homeopathy, you will appreciate that it has been hard for my students. I have spent lots of time teaching simple emergency remedies like *Arnica*, *Aconite*, *Ledum* and *Hypericum*. This proved to be very useful when the bomb went off at the hotel just 5 miles from the clinic, as all the students knew someone who was injured. And we have studied remedies for simple acute dis-eases and for the more common diseases of typhoid and cholera. Just recently I have become aware that they understand what is going on! We do a lot of role play, where one student is the homeopath and another has to learn a remedy for a particular disease and answer the homeopath within the remedy picture. It is lots of fun, and has made a huge difference to their understanding. They also sit in at the clinic and we discuss those cases that are within their capability. Another interesting challenge: try teaching acute *Belladonna*, *Lachesis*, *Apis* etc. where there is no change in the skin colour!

So, it has been a great journey. This is a wonderful country. It now has a new government, and the happiness on the streets is palpable. I have come to understand and respect the local people so much more. Many of my patients return to the clinic just to thank me for helping them. This is not only very thoughtful, it is vital to the audit that I have to compile.

We are constantly searching for funding. We need some chairs for the clinic – £5 would buy a sturdy wooden one carved by the local carpenters out of sustainable wood. I know if I had a MacRepertory it would ease the situation at the clinic, and a remedy machine would be lovely … If there is anyway you can support the programme, I would be enormously grateful. Please see the address below for further information.

Stay safe. *Tutaonana* ('we shall meet again') from Mtwapa, Kenya.

If you would like to support Alison's Frontline Homeopathy project, she would welcome materia medicas, repertories, a remedy machine, a MacRepertory, and/or money (cheques payable to ***Frontline Homeopathy – Kenya***). Pease send them to:
Frontline Homeopathy
3 Hanging Lees Close
Rochdale
OL16 3SG

Standing order forms with gift aid certificates are available, from:
Brookes@hanginglees.freeserve.co.uk

And you can find out more from the Frontline Homeopathy website:
www.frontlinehomeopathy.org

email Alison Pittendrigh on:
assiemel@africaonline.co.ke

Please note that the phone lines where Alison lives are stolen roughly once a month, and take about a week to ten days to be replaced, so be patient for a reply!