I would start by introducing you briefly to Cameroon and then to the place in Cameroon where I work and finally to the work I do and how it developed over the years. This will take about half an hour, after which I will do my best to answer any questions you might have.

Cameroon is a country of 15 000 000 inhabitants in central Africa. It is bordered by six other countries—Nigeria, Tchad, CAR, Congo, Gabon and EG. French and English are both official languages, although through vast parts of the country, including my own, almost no one speaks either one. Cameroon’s geographical zones range from tropical forests to mountains and foothills, plateaux, temperate coastline, arid savannah and scorching desert. Exports include lumber, coffee, cocoa, cotton, bananas, and soccer players. Politically, opposition parties have been permitted since 1990, although the same party has been in power since Cameroon gained independence in 1960. The current president, the country’s second in its forty-four year term, has been at the helm for twenty-two years and is due to be re-elected for an additional seven year term this October. There is an elected but very weak national assembly, and most other offices—prime minister, governors, district administrators—are held by presidential appointment.

Cameroon’s biggest cities, most fertile land, most vigorous development and its centers of political and economic power are in the broad southern base of the roughly triangular shaped country. If you are in the capital, Yaounde, which is in the south, and you happen to get hold of a very good 4x4 vehicle and if you pack a lot of peanuts and bananas and several gallons of water and jerry cans of fuel and if you are well rested, you can set out on a road headed north and about twenty-four hours later, assuming you do not stop, you will arrive in what is called the Far North province, and if you keep going to the far northwestern tip of this Far North province, nearly to the Nigerian border, you will come to a place called Kolofata. That is where I live, and here are some of the things you might notice right away.

The roads are dirt paths, and although bicycles appear to be the main mode of transportation—after walking, of course—there are also the odd motorcycle, horse and donkey. If you stop to wait long enough, you will see a car or a truck and maybe also an oil tanker transporting fuel from Nigeria to Tchad by way of Cameroon. The houses for the most part are mud brick with straw or sheet metal roofing, the roofs often held down by big boulders, and each family compound is protected on all sides by a mud brick wall. Lining the roads are wooden electric poles that hold out great promise, but in fact the electricity is intermittent and unpredictable. There is running water in places, but mostly water comes from deep wells and bore hole foot pumps, and usually around each of these you will see a few men loitering and trying to appear nonchalant and disinterested as they check out the women and girls who come to fetch water.

In the center of town is a mosque, for most of the people are Moslem, and beside the mosque is the market, where on market day, Friday and Sunday, you can buy onions and garlic and dried...
fish and salt and sugar and hot peppers and trinkets. Sometimes, you can buy a chicken, and
sometimes a bit of beef or mutton or goat meat.

If you go to the far western end of town and look left and up a little hill, you will see the Kolofata
District Hospital, where I work. It consists of four acres of land and six main pavilions: a
maternity and surgical ward, an OPD, a medical ward, a children’s ward, an isolation ward, and a
hodgepodge building with offices, ophthalmology, and x-ray and ultrasound. Each pavilion is
eighty feet by forty-two feet, painted yellow and dark grey, with long verandas front and back,
cement walls, sheet metal roofs, and ceramic tile floors. A number of smaller buildings—two
kitchens, a garage, a change-room, latrines, showers and storerooms—serve the six main ones.

Although we await the arrival of a surgeon this October, for the moment, I am and have been the
only physician in the only hospital serving a population that is officially 90,000 mostly very poor
farmers and herders. Unofficially, the population is about twice that. In other words, we keep
fairly busy. Ten nurses do the work of thirty, and twenty auxiliary personnel—translators,
cleaners, grounds men, night watchmen—complete the staff. Our set-up is simple and
unsophisticated, but over the years the hospital’s reputation has grown beyond its merits, so that
patients now come to us from four countries and hundreds of miles away for treatment. On an
average day we see 135 patients in OPD and round morning and evening on whatever in-patients
are occupying our fifty beds and overflowing onto the verandahs and into the courtyard.

Infectious diseases rank high on our list of diagnoses, and of these, acute and chronic respiratory
tract infections are way out in front. Malaria, amoebic dysentery and other diarrheas, a broad
spectrum of skin diseases, urinary schistosomiasis, and periodic epidemics of meningitis, measles
and cholera also figure prominently. Malnutrition—both marasmus and kwashiorkor—is
common in children, as is severe anaemia, particularly during the rainy season when malaria
takes its most dreadful toll. Our ophthalmology service, which we run with support from a
French NGO, offers general eye care and surgery for cataracts, trichiasis and glaucoma. We
extract about 300 cataracts a month, replacing most with intraocular lens implants and restoring
sight to thousands of blind people every year.

Beyond the hospital, I am responsible for supervising, developing and coordinating the activities
of six health centers run by nurses in peripheral villages and for interfacing with officials from
every level of government. In addition, our district is one of many points of execution for a
number of international initiatives including the global eradication of poliomyelitis, the
eradication of guinea worm, the elimination of leprosy, the Expanded Programme of
Immunization, and WHO’s Roll Back Malaria. The days, in general, are about seventy-two hours
too short.

It was not always thus.

I came to Kolofata in 1990, and although I knew I was coming to work in a government facility, I
expected to find something not hugely unlike the Nigerian mission clinic where I had just spent
six years. What I found took my breath away. The hospital, such as it was, consisted of a tiny
dilapidated cobweb-strewn building with two patients occupying six rusted cots. Thick red dust
coated everything—tables, papers, sinks, delivery bed. The packed-earth ground outside was
littered with discarded needles, giving sets, empty perfusion bags and bloody bandages all
massed like a hazardous moat encircling a derelict castle. I quickly learned the routine: the doctor
or one of the nurses received whatever patients came courageously by—on an average day they
numbered five or six—and prescribed and sold whatever sample or stolen drugs he happened to
have that day in his drawer. Needles and syringes were used and reused unsterilized, and for that matter uncleaned, for dozens of patients at a time.

The nursing staff of nine included three men whose usual state was one of inebriation and two others with dubious pasts who would go on to be convicted and imprisoned for a variety of crimes. Punctuality was considered more vice than virtue. Absenteeism was high and nurses would commonly go AWOL for days and weeks at a time. As government employees, it was nearly impossible for anyone to fire them, and they knew it. Except for an illiterate midwife, none of the hospital staff hailed from Kolofata, which was too poor and unschooled to produce anything so highly trained as a nurse. Most spoke none of the local languages and had been posted to Kolofata, the back of beyond, for disciplinary reasons.

The majority of the people who used the hospital were civil servants and their families, people from elsewhere in the country who themselves had been assigned to different government posts in Kolofata. The local people were highly mistrustful of the structure—it was a place, they told me, where one went to die—and mistrustful as well of all who worked there, including me. I sat from morning to evening day after day in a closet sized room, ready to welcome and advise and treat all comers, and the patient load of five or six a day and the unexpected silence never changed.

Yet the clamoring need for good basic health care was deafening. It was peak malaria season, and every day parents were burying their children. Women were dying of postpartum haemorrhage, babies of neonatal tetanus, farmers of snakebites, toddlers of diarrhea. An epidemic of yellow fever raged in one corner of the district. Guinea worm was crippling hundreds of people. Mothers and pregnant women knew virtually nothing of antenatal care, safe delivery, or vaccination.

It soon became clear that waiting for patients to come to me was not going to work very well, so I decided to start going out to see them. I hired a boy to be an interpreter and borrowed a car, a decrepit Renault-12 whose bald tires were stitched with cotton yarn and whose floor had rusted out. I unpacked my compass and set out along the dusty paths to map the district and to learn where each of its 100+ villages was and what it looked like and which language or languages were spoken there. I found a student willing to start teaching me a couple of the languages. Finally I got hold of some UNICEF vaccines from the government stores and I bought on credit a small supply of ten different drugs—penicillin, cotrimoxazole, acetaminophen, chloroquine, mebendazole for worms, metronidazole for amoebas, iron, multivitamins, gentian violet for wounds and fungal infections, and a topical scabicide—and I started going out to a few of our villages every week.

Typically, this is what would happen. I would arrive in the village and call on the village chief and explain that I had come to vaccinate the children against measles and tetanus and tb and to see the pregnant women and to treat the sick if there were any, and typically, the chief, standing firm with his head turbaned high and his feet spread wide and his arms folded across his chest would assure me that there were no sick people in his village, never had been, never would be; no pregnant women, no children needing vaccination. But I was welcome to stay, he would say, and see for myself. And so I would unload my little wooden folding table and stool and my cooler of vaccines and my box of medicines and I would set them up and sit under a tree and wait. And wait. In the evening, having served not a soul, I would pack things back up, thank the chief and tell him that if it was okay, I would return the same time next week.
And so it went for a few weeks. Mostly people hid behind closed doors. Occasionally a brave one or two would pass by and greet and keep on going. Finally the very very brave started urging or daring their old folk to approach me and tell me what hurt. When they did I would listen and examine them and prescribe some medicine, always taking a few coins or an onion or some okra in return. Eventually, my geriatric crowd was joined by younger adults and younger adults by children and pregnant women.

Still, the numbers were not overwhelming, back in Kolofata the hospital remained empty and unfrequented, and people still tended to run away when they saw me coming.

Then epidemic meningitis hit. It hit in a village of semi-nomadic herders, people much feared by the other tribes because they liked to settle differences and scores with knives and spears. When the epidemic started tearing through their village, some of the healthy loaded some of the sick on the backs of horses and rode to Kolofata and dismounted at my house. I led them into a straw lean-to in the courtyard and set the sick on mats on the sand, and I started them on drips and 2-hourly intravenous penicillin, nursing them round the clock. They all lived through the night, and the next day a couple more came and the following day still more. By the time the outbreak was over, we had lost one young man and saved the rest and word had rippled out in ever widening circles that the foreigner was not afraid to welcome and treat the “ruthless warriors” and the warriors were not afraid to go to the foreigner and take her medicine, and from that moment the wall that separated us did not come crashing down, but it did suffer its first pretty good crack.

I could tell you that the road was smooth and straight after that and it was just a question of cruising from one point to the next, but of course it was not. There was still the problem of our wildly undisciplined staff, a ramshackle and singularly unhealthy hospital, the dearth of drugs and supplies, and political conflicts and corruption that I cannot even begin to go into today. Nevertheless, I clung to a trusted mantra from my marathon running days—just keep putting one foot in front of the other—and every once in a while I could look back and see the distance that we had traveled, even if when I looked ahead the road seemed to go on forever.

I discovered that four or five years earlier a large field at the other end of town had been set aside for a hospital that was never built. With help from individual donors in the US we began bit by bit to build that hospital, adding a pavilion every two years. We cobbled together furniture out of locally available materials and expanded our stock of medicines. The Moore Foundation here in Indianapolis donated a Land Rover to replace the borrowed floorless Renault-12. Weekly staff meetings and determined efforts to see all, tolerate much and change one thing at a time helped bring the staff under better control, and I coped as well and as consistently or stubbornly as I could with corrupt government officials. From the beginning, we recorded every patient, every vaccination, and every delivery, for everyone knows that if you can’t measure it you can’t manage it, and it was clear from the outset that good management was half the battle.

The other half is good health care, individual as well as public. Not usually very fancy health care. When you work in such a place, your ears, your eyes, your hands and your stethoscope are your most valuable diagnostic tools. Add a thermometer, a sphygmomanometer, an otoscope and a watch with a sweep second hand and you are doing very well indeed. Laboratory investigations are limited to what can be done with a decent microscope, a minimum of glassware and a few reagents. Imagery if you are luck means plain films and ultrasound—which you do and interpret yourself. About 100 essential generic drugs are available and cheap, as they must be, for even in a public hospital patients pay for all their care, and any service offered is useless if it is not physically and financially accessible to the people who need it most.
This brings us to finances. Pharmaceuticals are renewed and operational costs are met through patient fees. These are not exorbitant. A medical consultation costs a dollar, a delivery plus postnatal care for mother and baby costs five dollars. A week’s worth of a broad-spectrum antibiotic—cotrimoxazole, for example—costs an adult 60 cents. A blood transfusion, including blood grouping and screening for HIV, runs about $8. A cataract operation complete with lens implant costs $20. The Cameroonian government contributes water and electricity, at least when the poles are up and the power is on, as well as $15000 a year to help pay for hospital maintenance and cleaning and office supplies. Donors from overseas fund most of the development work: building buildings and buying major equipment. A volunteer organization based in Canada provides my salary of $300 a month, which given the circumstances is plenty.

That last part may make the kind of work I do seem unattractive to many of you, but needless to say, it has an incomparable richness of its own. If you can imagine yourself doing it, you will realize that every day becomes an adventure, every encounter a learning experience. You do a little, or a lot, of just about everything. You treat the young as well as the old, the poor as well as the relatively well-off, men as well as women; you manage the so-called western but in fact universal illnesses like hypertension and diabetes and asthma but also the parasitic and nutritional diseases more associated with poor and tropical or semi-tropical zones. And you are usually dealing with ten or twenty more or less urgent problems at once: a malaria patient in coma, a lethal outbreak in some village, a leaking roof, a new snakebite victim spontaneously bleeding unclottable blood from multiple sites, a district administrator calling you immediately to an emergency meeting, a woman in labor with a breech.

There are frightening cases. You are called at midnight for a barely conscious woman who delivered earlier that day in her village and then failed to expulse the placenta. She is pouring out blood as if her uterus has a spigot with a cross-threaded tap that won’t turn off. You get her on the table and note her colorless tongue and her unseeing eyes, and blood is flooding everywhere. You reach in to empty the womb and as you do, terrifying thoughts pound in your head—and they are terrifying and they do pound; it is like being in a raging thunderstorm all alone in the middle of nowhere, and sometimes you have to look up to realize, with astonishment always, that the room is so still and quiet you can hear a graceful lizard brush against the floor—and the thoughts are along these lines: Am I watching this woman live the last five minutes of her life? If I don’t do something or do something else, will her children never see their mother again? And all the while you are giving orders to the nurse—position the patient, give the injection, start the IV—and going through the motions of clamping down on the uterus and reaching in, finding the edge, grasping and withdrawing, all with a methodical deliberateness you do not feel. (What you feel is like shouting at the blasted blood to just turn off.) In the end, the placenta is removed and the haemorrhage is stopped and the patient is stabilized, and when you leave the hospital at two in the morning you feel drained, as if half of that blood spilled on the floor had been your own.

There are sad cases. That scrappy one-year old you have been treating for several weeks turns out to have AIDS, and you realize again that of all your AIDS cases the ones you most dislike facing are newly diagnosed children, because of the colossal implications for the family. Almost always, the child has it because the mother is positive, although she does not know it yet, and the mother is positive because her husband is positive, and often as not it is a polygamous household so other wives are involved as well, and maybe other children, and in an area where there is no hope yet for treatment, it is wrenching to break this kind of news to parents. One can only imagine how instantly devastating it must be to receive it.
And there are wonderful cases. One Friday night in the middle of a howling duststorm you are trying to start a transfusion on a gasping seven-month old boy who appears to have not a single vein in his entire body. You are bent over him, ready to try a second or a third stick when suddenly the lights go out. You will learn later that the storm toppled three electric poles and knocked out power and that the power will stay out for five days, and by the way when the power goes out the water stops as well. In the darkness, the boy, his eyes rolled back into his head, is struggling for every breath. You could send someone into town to fetch the man who is in charge of the generator, but that would take forty-five minutes, or you could leave the ward and go out to the generator house and start the engine yourself, but that would take a half hour, and you don’t know whether this child has even fifteen minutes of life left in him. So you ask someone to light a kerosene lamp and by the orange glow you carry on trying to find the elusive vein in time to keep that life under your hands from going out like the electricity. You find it at last, and it is not too late. The blood starts flowing and not much later the bony chest starts heaving a little less desperately and the grey cheeks begin to lose their ghostly pallor and finally the mother’s solemn face relaxes and streams with tears of silent joy, and it occurs to you that that must be one of the most beautiful things it is possible to witness anywhere on earth.

My time is running out and you will be relieved to hear that I am coming to the end. And the end is this. By sheer accident or chance, you and I were born and grew up in the most privileged country in the world. We have wealth, we have education and health care, we have freedom to follow the paths we want to pursue and to be whatever we choose to be; we have the leisure to imagine and to create; we have never lived through war or famine or slavery. And if we, with all of these advantages, with all our resources and our knowledge and our good will—if we cannot lead the world to a better place, then who can?

We are searching our souls in America these days, and whatever anyone thinks of the events of the past few years, I doubt that many really believe that leadership is best practiced through the barrel of a gun. Albert Einstein said that example is not the main means of influencing people, it is the only way. As a nation and as individuals, we must lead through example, through understanding and compassion and involvement. As members of a noble profession, you and I are perfectly poised to do just that. I challenge the students in this room to learn about and to plan an elective in some downtrodden out-of-the-way place, stateside or abroad. Then once you qualify, think about dedicating a few months or better yet a few years of your life to serving those who need you the most. It is hard and sometimes frustrating and even overwhelming work, but it is exciting work and it is good work, for it is a commitment to the well-being of the poor and to the welfare of populations, and that ultimately is a commitment to peace.