TRAUMA

Civilian Conflicts in Nigeria: The Experience of Surgeons in Kaduna

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ABSTRACT

On February 21st –23rd 2000 Kaduna city witnessed a civil conflict resulting inevitably in mass casualties. Many dangerous weapons were used such as arrows, firearms, knives, and open fire. Two hundred and seventy three patients were seen in emergency unit of A. B. U. Teaching Hospital, Kaduna. One hundred and nineteen (43.6%) patients were admitted. The human and material resources were inadequate. Emergency resuscitations were carried out. Twenty-two laparotomies were performed without antibiotic cover. Many problems were encountered, as there was no established disaster management team. There was no adequate transportation system to convey the victims into the hospital and resuscitation materials were inadequate. We recommend that a standard disaster management team be established in our major hospitals and such hospitals should be well equipped to cope with these emergencies *(Nig J Surg Res 2000; 2:144-147)*

KEY WORDS: Civil conflict, emergencies, casualty, disaster management team, facility

Introduction

A disaster is a condition in which there is a sudden casualty overwhelming the material and human resources of the receiving hospital or an event in which ten or more people are killed. [1-4] Nigeria, like many other countries, is presently witnessing an increase in the rate of civil unrest because of the presence of atmosphere of freedom of speech and of worship.[5, 6] The principle of any disaster management is to do the best for the most.[7-10] On February 21st to 23rd, 2000 there was a civil conflict between two groups. This article reviews the management of the victims of the crisis.

Materials and Methods

The records of patients treated at the A. B. U. Teaching Hospital, Kaduna for injuries sustained during the crisis have been reviewed. They were analysed for age and sex, type of injuries, weapons used and the overall clinical management. The problems encountered were also reviewed.

Results

A total of two hundred and seventy three patients were seen. One hundred and nineteen (43.6%) victims were admitted. The remaining 154 patients (56.4%) were treated as outpatients, of which 3 were females. One hundred and seventeen males and 2 females were admitted (Table 1). The victims were mainly young individuals. The M:F ratio was 53:1.

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Table 1: Age and Sex Distributions of 119 Admitted Patients

Age (yrs)	Sex		Total (%)
	M	F	
<15	6	-	6 (5.0)
15-19	17	-	17 (14.3)
20-24	11	1	12 (10.1)
25-29	11	-	11 (9.3)
30-34	21	-	21 (17.7)
35-39	28	-	28 (23.5)
40-44	8	-	8 (6.7)
45-49	8	-	8 (6.7)
50-54	4	1	5 (4.2)
55-59	2	-	2 (1.7)
60+	1	-	1 (0.8)
Total	117	2	119 (100)

Table 2: Types of Weapons Used

Weapon	No. (%)
Firearms	123 (45)
Arrows	2 (0.7)
Cutlasses/Knives	82 (30)
Open fire	14 (5)
Clubs/ Sticks	52 (19)
Total	273 (100)

Table 3: Major Injuries Sustained by 119 Admitted Patients

Site of injury	No. (%)
Head/Neck	6 (5)
Chest	17 (14.3)
Abdomen	30 (25.2)
Limbs	66 (55.5)
Total	119 (100)

Different types of weapons were used (Table 2). The majority (45.1%) of the rioters used fire - arms. The injuries sustained were diverse (Table 3). Airways were secured, haemorrhages controlled, and fluids and blood were replaced urgently. Fractures were splinted and no analgesics administered as the patients wailed. A total of twenty- two laparotomies were carried out mainly for gunshot injuries. These were done with little or no antibiotics before and after operation. Four patients (3.4%) died on admission. Two of the patients that died sustained major vascular injuries, one who was a woman died of overwhelming wound sepsis. The fourth patient died of severe head injury. The casualties overwhelmed our medical facilities, however the available resources were mobilised for effective use.

The hospital had no established disaster management team and the resources were stretched to its limit; intravenous fluids and other resuscitation materials were inadequate and soon got exhausted. It took about 48hrs to make available some "grains" and "drops" of antibiotics. Two disaster wards were added to our surgical wards so as to accommodate the victims.

Discussion

Kaduna town is the capital city of Kaduna state. The city is a business centre that accommodates all categories of people from all over Nigeria. It has become a home city for many visitors who have decided to settle in this city permanently and have made it a home because of this serene atmosphere of peace. In Nigeria, like other developed and developing countries, there is increased terrorist activity and many people coming together with high possibility rate of disasters occurring.[7-11] Even in developed countries, disaster management is not an easy task as exemplified by the Keyworth M1 air crash and the Hillsborough tragedy in the United Kingdom in 1989.[1,2,8]

The civil conflict in Kaduna was an unfortunate situation. Many people were

affected. Our Hospital is one of the major receiving centers of Medical practice in this capital city. Out of the 273 patients seen, 43.6% were admitted, a reflection of the magnitude of the incidence. As in most conflicts, males were the most affected. An unconfirmed number of corpses were deposited in the morgue.

A number of difficulties were encountered; first and foremost, there was no disaster management team on the ground in the hospital for such eventuality. The transportation system was very poor as both private and commercial vehicles were off the roads. Many of the patients could not be transported to the hospital in time. Consequently, many reported for treatment after many hours of the injuries. Some who could be transported were brought to the hospital by the motorcycle. The medical team was apprehensive about the safety of their lives, as they were not particularly protected from possible assault. Most of them worked at very low morale.

Due to lack of resources, the baseline recording of the physiological parameters was poor. This was due to lack of manpower and material resources. Some significant injuries were missed initially as all cadres of medical and paramedical personnel were mobilised to undertake the roles of making diagnosis and treatments. Many patients were held up at peripheral hospitals before they could find their ways to the major hospitals where proper diagnosis could be made. The delay in transfer of patients into the hospital caused delayed diagnosis and treatments which increased morbidity. There were no adequate antibiotics, analgesia, fluids and blood for emergency use. The clashes placed a great demand on our surgical practices. We were only able to resume accepting normal elective patients after four weeks. Apart from the above, the costs to the society both directly, in terms of health care costs, and indirectly, in terms of the loss of goods and services were appalling. The cost to the individuals in terms of pain, suffering, incapacitations, disfigurements and loss of self-esteem cannot be estimated.

It is important to remember that any thing may happen anywhere at any time. The success of disaster management lies in a well-prepared protocol for early and effective mobilisation of human and material resources.[1-3, 7,11-13] Our recent experiences have placed us in a good position to recommend that disaster management teams should be set up and the team should be trained on how to manage disasters. The hospital should make disaster-training part of induction of all new staff; this will be of help when a major disaster is suddenly thrust upon us. Even when a disaster management team is on the ground, we may plan, prepare and rehearse with great care and attention to details. The management of disaster situation is hectic and almost impossible when there is no disaster management team on the ground. Society must learn to live peacefully. The experiences of the crises have greatly increased the skills of the surgeons in the management of trauma cases.

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