ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1. Describe the pattern of medical presentations to the Emergency department in the city of Dar es Salaam and compare this to the city of London

I spent my elective working in the Emergency medicine department (ED) at Muhimbili National Hospital. This hospital is described as the best in the country and is a major specilaist referral centre. Therefore emergency presentations (essentially self referrals) are a relatively new concept here following the build of the ED in 2010.

The department has several triage consulting rooms, a ward for patients under investigation and 4 resuscitation rooms with one dedicated to paediatric care. It was not unusual to see 4 patients in one resuscitation room during busy periods.

Similar to our set up in London, patients are triaged, discharged or admitted for investigation and specialist consults requested when appropriate.

Before arriving I assumed that I would see lots of trauma patients from road traffic accidents, but this seemed to make up a relatively minor proportion of the patients I saw. Most were patients with detriorating chronic conditions such as heart failure, COPD, asthma, TB, HIV etc. Many were not appropriately managed in the community or the cost for maintenance medication was unattainable or not prioritised by the patient. Therefore the most common presentation I saw in my time in ED was "respiratory distress query cause".

There were also several presentations of sickle cell crisis or due to malignancy e.g. urinary retention. All in all a more similar case mix to east London than I was expecting, but almost always the disease had advanced further than we would expect before the patient seeked help.

2. How does healthcare provision work in Dar es Salam and how does it differ from the UK?

There are 5 levels to healthcare provision in Tanzania; village healthcare, dispensaries, health centres, district hospitals and regional referral hospitals.

Village health services provide rural care in peoples homes. The providers are not medical professionals but have limited training to offer education on preventative measures to people in the village.

Dispensaries are walk in centres manned by medical aids (also not doctors or nurses) usually in rural areas. They may be visited by a doctor or nurse for weekly clinics/health checks. The medical officers are able to refer cases to district or referral hospitals. They offer community level care such as vaccinations, labour care etc.

Health centres tend to have more doctor, midwive and nursing presence and supervise the dispensaries. They often have beds and the capacity for in patient care.

District hospitals are the first level that are permanently staffed by qualified health care professionals. They take walk 85% of health expenditure is given to the central and main hospitals. But these hospitals access only 10% of the population.

Referral hospitals are staffed by multidisciplinary teams and strive to achieve "international standards'. There are 4 main ones in the country, including Muhimbili where i was based. The main barrier to their success is access and infrastructure. For example, although theres a great outpatient physiotherapy service offered at Muhimibili hospital, the majority of patients are not going to be able to travel there weekly to attend clinics. A doctor I worked with told me "85% of health expenditure is given to the district and referral hospitals but these hospitals are only accessed by 10% of the population.

Medical care is not free but can be heavily subsidised by the government for those with low income/ no insurance. While the elderly, children under 5 and those wth HIV or TB receive free care.

3. What are the pre-hospital care resources available to emergency patients in Tanzania and how does this contrast with the UK?

I discovered that there is no real formalised system for pre hospital treatment or transfer to hospital in Tanzania.

The onging struggles with transport and infrastructure have proven a barrier to its implementation. Furthermore the financial cost to the patient or patient's family for a first responder/emergency transfer may not be seen as worth it when the outcome is not guaranteed. Even within the ED department conversations were often had about the cost/benefit of a non-curative procedure. Similar to discussions we may have in the UK but rightly or wrongly our focus tends to be more on quality of life vs suffering rather than financial cost.

4. To improve my confidence in managing cases where language may be a barrier to establishing patient rapport

The main language spoken in Tanzania is Swahili, but all education from secondary school upwards is taught in English so anyone educated beyond this spoke relatively good-excellent english. This made things a lot easier for me as the national hospital staff were all obviously very well educated. The difficulty was communicating with some of the more rural patients.

I learnt to focus my swahili studies to areas that would help me attain the most oertinent information. Learning to introduce myself and role and phrases such as "where is the pain?" made a big difference to how useful I could be.

And even with the patients who did understand english, remembering to speak slowly and clearly and to regulary confirm understanding improved my interactions massively; techniques I hope to continiue to utitilse in future practice.