ELECTIVE (SSC5b) REPORT (1200 words)

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

Elective report Kenya

Describe the pattern of disease/illness of interest in the pediatric population of Kilifi, and how this is fits in within the context of Global Health

The main conditions which were seen during my time on paediatric high dependency unit was birth asphyxia, prematurity, respiratory infection as well as congenital heart disease. Experiencing such a high prevalence of birth asphyxia was the biggest difference in my experience of paediatrics in the UK and abroad. I could not belive the number of hcildren who died due to problems during labour. Many mothers experienced obstructed labour, and were not able to access a midwife or hospitals to help with this. Or perhaps many of them did not recognise that there was a problem. So many childrenw ere brought in floppy, barely alive, however in HDU we still tried to resuscitate them. Often, we left htem on oxygen and they were left to peacefully pass away. The other big difference wre the nuumber of children who came in dying from congential heart defects. In the UK I had spent time at Great Ormond Street Hospital in the cardiology unit. As such, I had spent a lot of time with children with such defects who were able to access high quality imagine and treatment for their conditions, and hwo were able to go on to live healthy happy lives. In my 6 weeks at Great Ormond Street- only one of the children on the wards died and it was an incredibly complex day. During my time at Kilifi 5 children died due to inoperable congenital heart disease.

Describe the pattern of health provision in Kilifi, Kenya, and compare this to the DGH and specialist pediatric experience in the UK.

The pattern of health provision was obviously completely different. Patients in Kenya do not have access to general practioners, which is a reason why patients present so late and so unwell. They will often visit a pharmacy who will charge them for some medicines which are not always directed at the problem. The hospital does not charge for services, however patients can go to a private hospital where they might get better care.

Describe the impact of the large paediatric research unit available in the paediatric departments, and how this compares to the clinical research you have experienced in the UK.

It was an incredibly interesting experience to see a research unit such as the one in KEMRI. There were a large number of British doctors who were working there, carrying out the lcincial reasearch. It

was incredible how many children were included into trials , which in the UK would not be possible., This is because of a large number of red tape barriers to including children into research, as well as the number of 'field workers' there were in Kilifi. These field workers would consent patients, so that the docotros didn't have to spend time doing this, which would limit the recruitment possible. Some of the clinical researchers were also working very limited clinical hours, so would always be 'on call' to come and assess a patient for a study. Also, as the HDU was funded by the reerach unit, there was a very special relationship between the reseasrch department and high dependency.

There was also a strange difference between the autonomy felt by parents in Kenya compared to the UK. In the UK the patients and parents seem to have more of an inclination to refuse participation in a study, as opposed ot in Kilifi where consent was often imlied before it was formally sought. There is more of a patriachal view of doctors in Kenya- often patients are not given choices so feel like they have less of one to make.

Describe the demands of medicine in a resource poor area, and how this impacts on the emotional burden of caring for unwell children.

My time at Kilifi has been an incredibly difficult, and I really think I was emotionally unprepared for my elective in terms of the number of children I have seen die, the number of times I have performed unsuccessful resuscitation on a child, and the level of responsibility I have been given during my time at the hospital. Though this is s strange thing to say, it was almost easier to see a child die from birth asphyxia, as opposed to the children who died from infection of congenital heart disease when they were older. Easier perhaps isnt the right word- it was always difficult to see a child die. It was different. One thing I found incredibly difficult was how 'normal' death was treated. We would be on a ward round, a child would die during ward round, we could attempt resuscitation, and after some time we would stop. The ward round would then continue onto the next patient, as if nothing had happened. In the UK we would probably be incredibly shocked by a death, spend time reflecting on how it made us feel, and how we could do better. Not a day went by in Kilifi when we didn't have a death, so in way you have to get used to it, you can't go home crying every day.

I feel that in the long term, it must be difficult to see the limitation of your profession- especially in a resource poor area when you know that in other areas of the world the children you are caring for would provide.