PAEDIATRICS

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Elective Report

I spent my elective in Kigali (Rwanda) and was based mainly at King Faisal hospital, a private hospital and therefore only accessible to those with enough money to pay for their treatment or those being sponsored by charities or organisations. However, I also spent some time at a C.H.U.K., a local tertiary centre accessible to local Rwandans. In both hospitals I was based on the paediatric and neonatal wards.

Objectives

1. What are the prevalent paediatric conditions in Rwanda and how has the 1994 genocide affected healthcare?

2. How is the care of neonates managed and what technologies and equipment are available?

3. Observe paediatric and neonatal care in a Rwandan hospital and contribute to their care according to my competencies

4. Gain an understanding into the difficulties faced by hospitals caring for patients in a developing country, and become more confident managing paediatric and neonatal patients.

When I arrived at King Faisal hospital I was expecting to see many tropical diseases, in particular malaria, but instead found that the majority of cases were similar to those found on the paediatric wards in the UK such as asthma. The doctors explained that in Kigali the incidence of malaria was decreasing, largely due to the widespread introduction of preventative measures i.e. mosquito nets. As a result I saw no cases of malaria in my 5 weeks in Kigali, although I believe this is probably not the case in the rural areas outside of the capital. The one disease that is still a major problem is HIV and many of the children we saw on the wards had contracted the disease from infected mothers. This was particularly true on the neonatal ward where several of the babies had been exposed to HIV in the Perinatal period. One mother who was HIV positive had given birth prematurely at 28 weeks to twins. Although the babies were born by caesarean section to help reduce the likelihood of transmission, both babies were being fed breast milk as the mother could not afford formula, thereby exposing them to a greater chance of HIV transmission. Another premature baby had originally been given formula milk as he had been born to an HIV positive mother, but she too could not afford to continue with this and began to breast feed. The mixture of the two types of milk in an immature gastrointestinal system had led to the baby developing necrotising enterocolitis, a severe and life threatening disease of the GI system. Following perforation of the intestine, the baby required emergency surgery and the withholding of all oral feeding. Although King Faisal is one of the top hospitals in the country, there are no paediatric surgeons and as a result there was no one to perform potentially life saving surgery on this baby. There was also no TPN (total parenteral nutrition) so while the baby was nil by mouth he was becoming malnourished. There were several other drugs and pieces of equipment that were not

available at the hospital due to cost such as indomethacin, a drug used to close a patent ductus arteriosus. The use of this drug prevents major cardiac problems later on in life often requiring major surgery and it was frustrating to see the consequences of this in another 9 year old patient knowing that treatment was available in other countries. At C.H.U.K. in particular there was a severe shortage of drugs and equipment and on many of the paediatric wards there were two patients to a bed. Oxygen was only available on one ward and there were no neonatal services available so all neonatal patients were referred to King Faisal. However, where there is a deficit in drugs or equipment there was an extremely high standard of care and problems were overcome in any way possible. For example, the baby with necrotising enterocolitis was unable to undergo surgery to repair the perforated intestine but the general surgeon suggested an abdominal drain which relieved the swollen abdomen and with supportive treatment the baby began to improve.

Other than HIV, the most prevalent childhood disease we observed on the wards was rheumatic fever which is becoming an increasing problem both in the capital and in the surrounding rural areas. Lack of early antibiotic treatment leads to many of these patients developing severe cardiac pathology and there is now a campaign aiming to increase awareness of the disease and educate people to seek early diagnosis and treatment. There is a huge drive to reach out to the rural areas in Rwanda with health care and education, and campaigns advocating safe sex and the use of condoms to prevent HIV are widespread throughout the country. Other campaigns are practised within the hospital; the kangaroo care campaign aims to educate new mothers of the importance of skin to skin contact between mother and baby and suggests a minimum of 10 hours contact per day. This is repeated to every mother during the ward rounds as the hospital has shown an improved prognosis in premature babies whose mothers have taken part in this campaign.

The genocide of 1994 resulted in the deaths of up to one million Tutsis and moderate Hutus and devastated the country both economically and emotionally. However, in the 17 years since the genocide a huge amount of financial aid has been put in to the country from the international community and the health system in particular has benefitted in the recent years. Health insurance is provided by the government to all Rwandans allowing everyone access to medical care whatever their financial situation. Private medical insurance is also available and it is mainly those who have private medical insurance who are able to afford the treatment at King Faisal hospital. As a result, King Faisal has many of the technologies found on the neonatal wards in the UK allowing the care of premature babies as young as 26 weeks.

One of the most positive aspects of my time in the hospital was observing the high standard of care shown by all medical staff to the patients. At both hospitals the ward rounds were carried out by the entire team and plenty of time was taken to explain treatments and answer any questions from the patients and their families. The ward rounds were well organised and at both hospitals the entire team were present at the morning handover meeting where difficult cases were discussed. My overall impression of the healthcare in Rwanda was that although there is clearly a lack of supplies and equipment in the hospitals, there is an incredibly high standard of care, and perhaps most importantly, due to the provision of national health insurance, healthcare is available to almost everyone.