PAEDIATRICS

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Mwanza, Tanzania

What are the prevalent paediatric conditions in Tanzania? How do they differ from the UK?

I spent four weeks working in Sekou – Toure Regional Hospital in Mwanza, Tanzania. During that time I worked primarily on the paediatrics ward, helping the only doctor there with the ward rounds in the morning and other jobs on the ward. Very early on in my experience, it became clear that there were a rather limited number of diagnoses being made on the ward. These were malaria, ADD (acute diarrhoeal disease) and pneumonia. These are essentially very different – if not differently named to the sort of conditions that you see in paediatrics in the UK. Malaria is obviously very uncommon in the UK and Tanzania has a high level risk throughout the country. It often presents with a high fever, malaise with or without some gastro-intestinal or respiratory symptoms as well. This means it is very difficult to specifically differentiate it from the other two common conditions seen; ADD and Pneumonia, and therefore they are quite often diagnosed as a triumvirate. Another interesting thing about malaria is that the only way that they are able to test for it in Sekou – Toure hospital is via a blood slide in a thoroughly under funded and basic laboratory and therefore it is sometimes missed as a diagnosis. However, if there is any doubt of malaria (essentially a higher fever) then treatment is started. They treat with 6 doses of quinine IV over 48 hours followed by Alu for 3 days. The other two conditions are diagnosed based on symptom description alone very often; with a history of cough pointing to pneumonia and any GI upset pointing to ADD. The latter is treated with oral rehydration salts and zinc and the former with a seemingly random selection of the few available antibiotics. The most important difference between these conditions and how they are managed in UK and Tanzania is that in the UK, it is possible to discover the causative organism of any infection much more easily and this will result in a more appropriate treatment, whereas the hospital I worked in Tanzania did not have these facilities.

How is paediatric healthcare (particularly sub-specialities) organised and delivered in Tanzania? How does this differ from the UK?

I wrote this objective whilst in the UK and over my time in Tanzania it has transpired that it is not really that relevant particularly for the hospital that I was working in. In Sekou – Toure, there were two paediatric wards. These were covered by one senior doctor, who was not specialised in paediatrics. General medics in Tanzania – particularly those who work in the regional government funded hospitals often work in rotations of 6 months to two years in the larger specialities – such as obs and gynae and paediatrics. The doctor who I was under had not specialised in paediatrics let alone a sub-speciality therein. The only sort of division there was at Sekou - Toure was that some of the patients with burns were kept in a ward on their own but they were not attended to by any specialised healthcare staff. In the larger hospital in Mwanza that I also attended for a day to experience the differences, there was a greater degree of specialisation. There were doctors there who had been specifically trained in paediatrics but seemingly they did not

have any further special interests. This is obviously very different from the UK as any paediatrics doctors have undertaken particular specialist training and by the time they reach consultant level have started to develop special interests that they can then further sub-specialise in.

How does the availability of healthcare to children in Tanzania differ based on where they live?

There are essentially four levels of healthcare in Tanzania, where I was on placement and I was fortunate enough to experience all of them. The first line of healthcare for a lot of people is the traditional healer who lives in the smaller village communities. After spending a day with one I was surprised to discover several things about these healers. First, they are often very religious and claim that their visions come from God (be it through the Islamic faith or the Christian faith). Second, there are four different media through which the healers are able to ascertain what is wrong with the patient and this is either through tealeaves, chickens, twigs or dreams. Thirdly, they are hugely respected and even people who work as technicians and other positions in hospitals etc. may still go to healers as a first line. The next step up in healthcare is the government run regional hospitals of which Sekou -Toure where I was placed is one of them. These hospitals are basic to say the least and are typically very under funded and understaffed. The advantage of these hospitals is that they are cheaper than other hospitals as they have been subsidised by the government. The next level is Missionary hospitals. The location of these hospitals is seemingly sporadic and depended on where missionaries have settled in the last century. They are slightly better equipped than the governmental hospitals but are often quieter though as they are more expensive. The final level is the internationally assisted tertiary referral hospitals. There are only a handful of these in Tanzania and one of them is in Mwanza. Patients only end up here if someone refers them at a smaller hospital or private health clinic or if they are admitted via casualty. So, to answer my objective, the availability of healthcare is highly dependent on what type of hospital the local hospital is, how near it is and also how much money the family of the child has to spend on healthcare.

Reflective objective

I feel that I have been able to improve my clinical skills in Tanzania. This has been facilitated my some interesting paediatric cases seen on ward round and also patients seen in general medical clinics. As I was treated very much like a colleague of the doctor rather than a medical student, I was often the only person to perform an examination of the patient. This was daunting at first but because some of the signs that are more subtle in UK, such as splenomegaly, have so much more time to develop in Tanzania due to lack of primary healthcare, I was able to see the signs and develop confidence in what I was eliciting. I will use all my experiences from my elective when I come to start work in August and think that hopefully they have made me more proficient at confidently determining signs from a patient.