GENERAL MEDICINE

Elective Report
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Location – Teule Hospital, Muheza, Tanzania
Dates – 22/4/13 – 24/5/13

Elective Subject – Medicine and Surgery

Elective Supervisor – Dr Aubrey Maonga

Objectives

1. What is the prevalent disease burden in Tanzania and how is this different to the UK?

In the UK, chronic diseases such as Hypertension, diabetes mellitus and IHD provide much of the disease burden. Mortality comes from IHD, stroke and cancer. Communicable disease remains the most prevalent disease burden in Tanzania and leading the way in morbidity and mortality is malaria. 95% of the population are at risk and it is responsible for 33% of hospital admissions and over 54% of hospital deaths. Of course these figures don't count the silent majority which never reach hospital and are never reported. In Tanga Region malaria prevalence amongst the under-5s is at 13.9% but this figure can be as high as 41% near Lake Victoria.

Malaria treatment is free for the under-5s and for pregnant women due to funding from the WHO. However, at many hospitals the laboratory cannot provide testing facilities. Teule is unusual in this respect and provides cheap and accurate testing via cost sharing. Further government action against malaria is targeted in primary prevention – promoting the use of insecticides and infused mosquito nets. Efforts to date report that ~25% of under 5s now sleep beneath a net and private and faith-based initiatives are working hard to increase this. Thankfully there is little chloroquine resistance as yet in malaria although p.falciparum is the most common organism found. As patients present late and cannot afford all treatments (eg fluids), prognosis for severe malaria is often poor. Patients presenting with fatigue, reduced GCS, abdominal pain, fever fits jaundice and organomegaly are all treated with a high clinical suspicion of malaria and are started on treatment immediately without waiting for the results of testing. Severe malaria remains of all the differentials that I saw whilst there.

Typhoid, dengue fever, yellow fever and rabies are all endemic to Tanzania, as with any tropical climate, but their second great infections nemesis remains HIV. Despite education programs from the government it remains a taboo illness and transmission, both vertical and sexual, remains high. Condoms are a luxury most cannot afford, and strong religious element dominates social behaviour, keeping discussion of key issues underground (it doesn't stop the sex of course!). Again through the WHO, funding is available for HIV testing and treatment (ARVs and key antimicrobials) so that it is free for all. HIV testing in hospital is

commonplace, and is done with appropriate counselling for the patient, and this was encouraging to see with regards to reducing taboo.

No writing on HIV would be complete without mentioning its close companion TB. This is also very common in Tanzania, the second most common respiratory complaint, especially in HIV positive patients. Quadruple therapy, again through the WHO, is available, and TB remains of most respiratory differentials at Teule. Sputum cultures are available, complete with necessary stains, and the surgeon's skill in inserting chest drains is famous in the region.

2. How does Tanzanian healthcare provision differ from that in the UK?

In the UK nationwide taxation funds free-at-the-point-of-care healthcare for all UK and EU member state nationals and those resident in the UK. Funding is now allocated via GP-led commissioning groups. Policy is driven by the Department of Health. Centrally, Tanzanian healthcare policy is organised similarly by the Ministry of Health and Social Welfare. They divide their nation up into districts, each served by a district hospital (~250,000 patients), with multiple walk-in centres (~50-80,000 patients) and dispensaries (8-10,000 patients). A referral or regional hospital serves 4-8 district hospitals and four consultant hospitals top the pile. With no GPs, patients self-refer and healthcare is paid for by the patient, subsidised in some areas by both the government and NGOs.

Teule Hospital is 40% funded by the Anglican Diocese of Tanga Region and reveives further funding from German organisations for its ground-breaking palliative care service, set up 10 years ago by a british GP. Only a small proportion of Tanzanians can afford hospital services, although many will buy antibiotics cheaply from their local dispensary. Still more still cling to the traditions of the witch doctors, the results of which all-too-often come to the hospital when it is too late. Patients tend to present very late in any case, so clinical signs are plentiful and outcomes are poor.

Despite its better than average funding, Teule hospital still lacks basic equipment and the means to keep it running. They possess a good xray department and an ultrasound machine. Both of these are cheap for patients and so are well used. The laboratory is well run, using WHO money to provide cheap accurate malaria screening and testing, and its own funding to provide stool/blood/sputum cultures and sensitivities, and cytology (eg urine, CSF). Blood tests available include Hb, HIV and blood glucose, but do not include U+Es or LFTs. They possess the machines for both of these but are not used routinely because the air conditioning in that room is broken and they wont work.

Doctors therefore rely on their clinical knowledge and skill in diagnosing their patients. The MD trained doctors are mostly excellent, although in comparison to UK doctors, take great pains to not over investigate their patients, because in many cases the additional information would make no difference to management or prognosis. Many clinical decisions are made by Medical Officers, trained for a single year, and although supported by the MDs as much as possible, their inexperience in many cases is telling.

3. How is healthcare and the medical profession perceived in Tanzania and how is this different to the UK?

Doctors are treated with great respect in Tanzania. Not only are they some of the most educated people in the country, they remain pillars of the community, involved with church and education and social welfare projects. People's continued use of witch doctors does not stem from their mistrust of medical doctors, but simply that they are more available in remote communities (patients must travel to the doctor themselves) and of course don't charge if they cant fix you, whereas doctors charge irrespective. The medical profession is held apart from the public by its continued use of English as the medical language, which is problematic in a country where the education system is failing since its golden days in the 1960s under Julius Nyere.

4. Develop confidence in clinical practice and reflect on maintaining professional standards under stress.

I have thoroughly enjoyed my time at Teule. I chose to come to Africa to experience something I would not otherwise – a totally different healthcare system and indeed way of life. I was not prepared for the vast difference between the Western ideals of hard work and earning a wage, and the African ideals of self-interest and doing the minimum work necessary so that friendships and family can be attended to. 'Hakuna Matata' was not the phrase I thought it meant. Whilst it does mean 'no worries' is terms of being relaxed and not getting stressed, it also reveals a laissez-faire attitude that in healthcare leads to shoddy work, a lack of accountability, abandoned standards and a system that certainly doesn't place the patient at the heart of anything.

I was however excited to have to rely on my clinical skills and knowledge far mare than high cost tests. In this regard the elective has not disappointed. I have had to adapt my surgical sieve to include tropical medicine. I am now more acutely aware of the importance of the initial assessment – using my eyes and hands to examine a patient to get vital clues about their condition from simple measures like temperature, warmth of skin, and signs in the eyes. I am far more adept in palpating the abdomen because there was not the fallback of CT scanning. I have seen many clinical signs at late stages, that simply do not occur in the UK as patients present late in Tanzania.

Overall my elective has given me perspective. I have seen another way of healthcare provision and I can compare it to my own. It is not simply a difference of resources, but an attitude that marks a difference in how we, as doctors, can choose to act. It has encouraged me to strive for excellence for my patients whatever the resources available to me.