Elective Report April/May 2014
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Objectives
1. What are the prevalent medical conditions that require hospital admissions in Tanzania and how do they differ from those we see in the UK.
2. How are health services organised and delivered in Tanzania?
3. How do the government and NGOs help deliver healthcare to those furthest away from the major hospitals?
4. I would like to strengthen and improve my history taking and diagnostic abilities and reflect on how this can improve upon what I have already learnt from medicine in the UK.

1.
My time in Tanzania has been an unparalleled learning experience that I will treasure for the rest of my life. It has been filled with opportunities to develop my clinical skills, my diagnostic acumen and strengthen aspects of my personal communications skills.

My placement was carried out at the Muhimbili National Hospital in the largest city of Tanzania, Dar Es Salaam. I worked mainly in the gastroenterology, cardiology and one of the general paediatric wards. It serves as a referral centre for cases that could not be managed at the regional district hospitals in other parts of the country as well as seeing other local and private patients.

Many of the cases seen in the gastroenterology wards were chronic hepatitis patients with gross ascites, hepatic cancer, portal vein hypertension, severely cirrhosis livers or gross hepatosplenomegaly all often usually secondary to viral hepatitis and sometimes co-infection with HIV but also alcohol. In the clinics however, patients often presented with gastro-oesophageal reflux disease, chronic peptic ulcers due to H. Pylori or lifestyle related factors other conditions I encountered were inflammatory bowel disease that is often treated as gastroenteritis by inexperienced doctors before coming to the attention of the specialists at Muhimbili. I also spent time in the endoscopy suite where they diagnosed ulcers and other GI malignancies. Health statistics about specific conditions are extremely hard to come by in this healthcare setting.

In the UK the majority chronic liver disease patients have alcoholic liver disease and the prevalence of viral hepatitis is significantly less than it is in Tanzania. Many patients in the Uk also have chronic peptic ulcer disease and the complications associated with them. Also the extent to which many of the patients has deteriorated on the wards likely reflects late presentation and a lack of resources to afford or travel to a health facility in Tanzania and misdiagnosis in peripheral hospitals.

In cardiology cardiomyopathy and heart failure were by and large the most common conditions patients presented with. Cardiomyopathy was secondary to peri partum disease and untreated hypertension. Heart failure was often rheumatic heart disease. Many of these patients were under the age of 30. There were also cases of heart failure secondary to uncontrolled essential hypertension and that due to other secondary causes e.g. Renal artery stenosis, ischemic heart disease, infective endocarditis, congenital heart defects and more rare conditions like Epstein's anomaly, pericardial and even Marfanoid valvular heart disease.

This is in stark contrast to the Uk's massive prevalence, morbidity and mortality associated with ischaemic heart disease. The vast majority of the patients in cardiology are over 50, and the incidence of cardiomyopathy and particularly rheumatic heart disease are extremely low low in comparison.

In paediatrics malaria was extremely common, especially as I was in the National referral hospital there were often severe cases of cerebral malaria. Infants were often admitted with acute upper and lower respiratory tract infections. The general ward was split into bays for the different system specialities respiratory, gastroenterology, nephrology . There were several more specialised paediatric wards that I didn't get to spend any time in, including diarrhoea, malnutrition, paediatric oncology and paediatric and neonatal intensive care. The UK often sees a large volume of respiratory tract infections other common reasons for admission, but the malaria, malnutrition, and other infectious disease are not common. Childhood cancers included most commonly Burkitt's Lymphoma, the acute leukaemias, Wilm's tumours, neuroblastomas and retinoblastomas.

2.

The healthcare infrastructure is organised in a pyramid system beginning at the village level and ending at the top with regional referral hospitals. At the village level there a clinic managed by health workers who offer preventative services and advice on accessing further medical care. The next level is the dispensary that supervises a group of village health services. These dispensaries feed the appropriate patients into larger healthcare centres. The next level of health care is provided by district hospitals then regional hospitals and the highest tier of care is provided by the four consultant referral hospitals covering the northern, Southern, Eastern and Western regions.

3.

I worked with an NGO called Tumaini La Maisha which means "Hope for Life" in Swahili. Their primary aim is to provide a free hostel for children undergoing cancer treatment from distant regions and their accompanying parents. They often are unable to afford, and far too unwell for return journeys between cycles of chemotherapy which is provided by another charity called children in crossfire but is being taken over by the Tanzanian government. There is only one centre properly equipped to treat childhood cancers in the entire country at Muhimbili. In much of the rest of the country the roads are not accessible, transport is unreliable and dangerous, the ability to diagnose the children is limited by a lack of equipment and public and professional knowledge. Families are often too poor to seek western healthcare and even if they do they are often misdiagnosed and labelled with more common conditions like TB and malaria. TLM in partnership with another group called

Friends of children with cancer in Tanzania FOCC, work to help to educate health workers and local people in remote areas of children with cancer and help to bring them to the treatment centre. Parents usually mothers face the difficulty of giving up their livelihoods in order to stay with their children for months at a time and provide a service to help the parents generate an income whilst their child is receiving treatment.

The issues faced by this charity in supporting childhood cancer are a good example of the difficulty the country faces in delivering healthcare in remote areas. The government relies on public private partnerships often with charities in order to help promote health awareness and delivering healthcare in the more remote regions.

4.

Due to the language barrier for the majority of patients and the lack of translators the opportunity to take histories was extremely limited. Therefore I was unable to get an opportunity to practice my skills much. However that being said, medicine in the UK is increasingly being delivered with the help of interpreters or advocates. It is increasingly important to be able to work with these colleagues to help deliver the most effective healthcare service possible. The opportunity to work with interpreters usually local medical students, nurses or doctors here, will prove beneficial to my practice in the UK. I was able to put into practice many of the principles I already learnt from my curriculum in the UK. The things I will take from the experience are the importance of always addressing the patient directly and learning about local cultures and customs and how that can affect health seeking behaviour and treatment compliance.