Objectives

1. What are the most common paediatric presentations in The Gambia? How do these differ to the UK?

The most common paediatric presentations depend upon the time of year. Whilst I was working on the paediatric ward the most common illnesses were pneumonia and gastroenteritis. This time of year it was typically pneumonia season due to the dry, dusty conditions. Due to the over prescribing of antibiotics many of the children had drug resistant strains of bacteria, which meant they were hospitalised for many weeks and presented very seriously unwell. Whilst many children in the UK present with respiratory distress at certain times of the year it is not common for children to present seriously unwell with drug resistant pneumonia. However drug resistance in also a problem in this country it is not common to see 4 to 5 children each day with multidrug resistant causes to their respiratory illness.

Another common presentation was "fall from height" as the children had been climbing mango trees in order to pick them the mangos to sell. Fall from height is certainly a cause of emergency admission to UK hospitals; it is not usual for young children to fall from such large heights.

At other times of year, during the rainy season, the most common cause of childhood admission to hospital is malaria. This can cause the hospital to be full to capacity and beyond, often with 5 or 6 children sharing one bed due to lack of space. Malaria is not a common disease seen in the UK and is only seen in those individuals returning from malaria endemic areas. Also there is never a situation when children would be sharing beds due to lack of room.

2. How is paediatric healthcare delivered? How does this differ to the UK?

Paediatric healthcare is delivered in a very similar way to in the UK when there is a medical problem. There were a number of paediatric wards, side rooms for those who were infectious or critically unwell, emergency beds which were closest to the nurses/Drs station and were newly equipped with oxygen ports, and beds further away which were for less unwell children. At this time of year there were empty wards as it was relatively quite compared to malaria season. However for those children with surgical problems they were looked after on the surgical ward and placed in with the adults. Children suffering with TB were sent to the specialist chest ward and those with HIV were looked after by the infectious diseases unit.

The medical wards are similar to how paediatric care is delivered in the UK, even to the point of bright colourful murals on the walls to make it more child friendly. However in the UK the children with the specific diseases mentioned would be still be looked after on paediatric wards, even if they were specialist paediatric wards.

In The Gambia health care is free for under 5s, those over years old have to pay a fee of D25 in which they get an initial consultation, any laboratory tests that are deemed necessary and any medications they may need during their stay (if it is deemed appropriate to admit). This is different to the UK where in primary care prescriptions are free for under 16s, under 18s in full time education and consolations/hospital stays etc. are free on the NHS at the point of care.

3. How does the spread of general medical admissions compare to the UK?

There were a number of conditions in The Gambia such as malaria and severe anaemia that are not commonly seen in the UK and it was interesting to experience their presentations, investigations and management. However there were also a lot of admissions caused by

diseases that are very common in the UK such as hypertension, stroke and diabetes. The biggest difference when considering these conditions are the stage at which patients present and the way in which they are managed after diagnosis. I was surprised by the prevalence of type 2 diabetes, which in the UK is generally a disease related to obesity. The individuals I was seeing in The Gambia were not the typical overweight patients. This is due to the fact that there are vast quantites of sugar used in a typical Gambian diet. Due to late presentations and lack of effective primary health care many diabeteics present with neuropathies and ulcers.

4. To experience a healthcare system in a developing country and improve my clinical skills without relying on medical technology available in the UK. A daily diary will help me reflect.

The healthcare system that I have experienced whilst working in Farafenni general hospital in The Gambia has enabled me to experience a healthcare system that is completely different to that of the NHS. In contrast to a healthcare system that is free of charge at the point of delivery there was often a cashier present during a consultation in order to take payment for investigations such as ultrasound scans. Often individuals were turned away from such investigations because they did not have the ability to pay the necessary fees. There were a number of occasions where families were asked if they wanted specific investigations as they would cost more than the initial consultation fee, this was in contrast to the UK where even though permission is gained before tests are carried out the concept of costs are not usually the deciding factor for families.

The employees of the hospital and their immediate families were entitled to receive treatment free of charge. This opened up a lot of room for manipulation of the system with employees bringing in their friends and extended families and expecting to receive free treatment. There was also lack of consistency in dealing with those individuals who could not pay, some were allowed to have the investigations, some were allowed to only pay half and some were turned away at the door. It all seemed to depend on which doctor you saw and the mood they were in that day.

An interesting aspect of the health care system was the way in which they dealt with the blood stocks and giving blood to emergency patients. Those individuals who need blood immediately are able to receive the blood they need, however before they are able to leave the hospital one or more of their relatives have to replace the units of blood that have been used for that patient. For those patients that are not emergency but need a blood transfusion, e.g. in those who are critically anaemic, their families have to give blood to the blood bank before they can have their transfusion. There is no national blood bank as in the UK, and the idea of healthy individuals donating blood regularly has not filtered into this community.

Another interesting aspect of the healthcare system was the way in which management of some conditions deepened upon what was available in the pharmacy rather than simply what is the best drug or treatment options for this disease in this person. Often antibiotics were chose not due to what bacteria were being target but simply what they had available. This was similar in the management of a lot of diseases. The readiness to prescribe antibiotics was also alarming, there did not seem to be any regard for future drug resistance due to the amount of antibiotics that were being prescribed when there was no indication to do so.