ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

What are the common conditions seen in an acute setting in Dar es Salam and how does this differ form the UK?

In Tanzania, Accident and Emergency is known as casualty. During my rotation in casualty, I saw a varety of cases and learnt a lot. However, there were certain recurrent cases that were very common. On of the common presentations was an unwell patient who had systemic sepsis. These patients had sepsis secondary to a number of causes such as urosepsis and infected ulcers; usually diabetic or venous ulcers. They usually presented in this manner as patients tend to delay going to the hospital either due to distance or fear of the costs of healthcare.This is different from the UK where patients tend to present earlier and therefore have not yet developed systemic sepsis.

Another common presentation was patients presenting with non-specific symptoms but were generally unwell and their vitals were abnormal. Usually these patients were found to have HIV with a low CD4 count.There are many reasons for this late presentation including non-adherence to medication and follow up, promiscuity and lack of precations as well as not presenting for testing. More commonly, a lack of education and the stigma associated with HIV results in the poor state of the patient. There are good facilities for such patients, however a large number present late with shortness of breath due to PCP infections. This is different from the UK where there is better education of the populus, less stigma and good adherence to medication and follow up as a result. Furthermore, UK law allows doctors to break confidentiality in order to protect an individual other than the patient who might be harmed if he/she was not aware the patient had HIV. This is not the case in Tanzania as it is illegal to break confidentiality.

The third common theme was patients presenting with either hypoglycaemia or uncontrolled diabetes leading to HHS or DKA. This was usually because patients were either undiagnosed or were lost to follow up and therefore their management was not optimised. This was very common and lack of education about the dangers of diabetes plays a major role.

How does healthcare provision work in Dar es Salam and how does it differ from the UK?

In the UK, the healthcare system exists as the National Health Service (NHS) which is a government body that provides free treatment to all. Such a system does not exist in Tanzania. There is also no standardised GP system like the UK. In Dar e Salam, there are multiple dispensaries, clinics which offer some specialist services, private consultant clinics as well as hospitals. Patients have a choice as to which facility they utilise. Hospitals are either private or government hospitals. Shree Hindu Mandal is a private hospital with a good reputation. Reputation plays a big role in why the patient chooses a certain establishment. Patients can be cash patients or have insurance. There are many types of insurance but the private ones tend to cover more consultations and investigations. The main government insurance body is NHIF which is also the cheapest to get at a price of about 100,000 Tshs (£40) per year. However, not all hospitals accept NHIF as they are sometimes tough paymasters and they do not cover a lot of investigations and are

therefore limited in their provision for the patient. For example, they do not cover HIV testing and the patient would be required to pay for this test. Such issues about payment take up a lot of doctors time as it has to be negotiated with the patient and their family and has to be billed before any action is taken. This can cause delays and limit the extent of treatment provided to the patient which is very different to the system in the UK. Sadly, it is poor patients that suffer the most in such a system.

To observe the workings of a healthcare system in an underdeveloped country and appreciate the different approaches to prescribing and health management

As mentioned above, finances play a major role in medicine practiced in Tanzania. The approaches of public health, general organisation of the health system and how medicine is taught is also different. For example, I was surprised to learn that ECG's are not taught as part of the medical cirriculum and is expected to be learnt individually. The teaching system among doctors and nurses within hospitals is also different.

It is important to note the above when discussing how prescribing and health management works in practice here. All medications and investigations are prescribed and billed before they are performed. This can delay treatment, especially of a seriously ill patient. Furthermore, most hospitals have their own pharmacies and dispensaries that stock the prescribed drugs. On many occasions it was found that certain drugs were not prescribed because they were not available in the pharmacy and the doctors had to do their best to work around such issues by prescribing the next best thing. Visits by drug representatives was also a common theme as they sought to promote their drugs with doctors and hence raise awareness and sales. Doctors are often also crippled in their ability to treat due to finance issues as well as having to deal with extreme complications of diseases due to the patient avoiding assessment by medical professionals for as long as possible. For example, I saw a case where a diabetic ulcer had maggots growing in them and the patient had sepsis due to not seeing a doctor for 2 years about his diabetes. These strange circumstances result in doctors having to make difficult decisions to treat their patients who are complex in their own unique way.

To gain confidence in managing cases where language is a significant barrier

The main language in Tanzania is Swahili. Although I lived in Mombasa, Kenya for 16 years and speak a bit of Swahili, it was still very challenging to talk to patients and explain medical jargon to them. Hence, language was still a significant barrier. Furthermore, the Swahili spoken in Tanzania is slightly different from that spoken in Kenya and this added to the barrier. The difficulty was especially evident when taking histories and talking to patient's families. Diagnoses and medical jargon had to be explained differently as there is no direct translation for the words in Swahili and this makes it more difficult to communicate with patients.

In practice, I learnt to adapt and learnt new skills in the process. When speaking to patients, the input of doctors and nurses was invaluable and I learned how to ask for help when I was stuck. Furthermore, the nurses were very accommodating and taught me common phrases that

patients with even a low education background could understand. For example, diabetes is known commonly among the populous as the 'sukari', which is the Swahili word for sugar, and hypertension is known simply as pressure. This led to greater confidence in managing cases and allowed me to function better in this new and alien environment.