Uganda – a life changing experience

Elective report
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Uganda – a life changing experience.

Africa has always intrigued me. When I was young I read stories of adventurers sailing to the "dark continent" to explore the mysteries and richness of its vastness. When I set off on elective, I really didn't believe that I could actually feel like an adventurer. I had no idea what to expect. The only pictures I'd seen of Africa were of starving, miserable children and the wildlife on the television programme Big Cat Diary. How different it really was!

I had set out a number of objectives to achieve in my eight weeks, these were;

- To experience medicine in a developing country
- To teach from the book "Where there is no doctor" in a community setting, explaining how to recognise and treat common illnesses.
- To work with children in a hospital setting
- To observe and understand the presentation, course and treatment of diseases such as malaria, HIV, AIDS and TB.
- To be immersed in Ugandan culture so that I can understand how culture impacts upon attitudes and response to illness.
- To witness surgery, ward rounds and patient care in a Ugandan hospital.
- To revise general medicine and surgery for my finals and to broaden my knowledge so that I become a better doctor.

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First Impressions

Sally a fellow fifth year medical student and I had lots of help and guidance from many people while we were in Uganda so that we could reach our objectives. Our travelling companion Barbara works for a charity that does many things in Uganda. Barbara was our guide and mentor; she introduced us slowly to the country and then let us go our own way (under her watchful eye). Mobile phones were incredibly useful as there are no land lines so all distance communication is done via mobiles or the ancient internet that produces one page a minute.

We had to learn the culture very quickly as although Ugandans speak English as their language of business and schooling, most things are very different from England and we could have unknowingly offended a lot of people. There are certain unspoken rules you must abide by. In the villages women must wear long dresses as trousers are the attire of prostitutes, women must also not display any from of affection towards a man in public. Men must wear long trousers, not shorts, as this is a mark of respectability. Also when driving you must take your life into your own hands and overtake up blind hills, drive as fast as is possible without hitting too many potholes or pedestrians carrying large loads on their heads and you must expect everyone else on the road to under and over take you simultaneously on a two lane, dirt road!

My first impressions of Uganda were how green and busy it was. Everywhere I looked there were women and children walking by the side of the road carrying water or baskets of potatoes or charcoal on their heads. The shops by the roadside were basically wooden shacks but they were teeming with life and crammed with goods. Even when you get into the villages and the communities are spread much further apart you are never far away from someone farming, driving cattle and most definitely you are never far away from a small child who when he sees you will scream with delight and either hop up and down or run after your car shouting “jambo, jambo, jambo! Muzungu byeee!!” (This means hello, hello, hello! White person goodbye!) The dirt roads are a bright paprika red and the sky looks huge because there are no tall buildings to obscure it,

especially at night when you can see the multitude of stars and the Milky Way curving across it.

Medicine in the community

Our first real introduction to medicine in Uganda was on an island called Buvume in Lake Victoria. It took two hours by boat to reach and we were carried to shore by some strong Ugandan men so that we wouldn't have to put our feet in the lake which is highly populated with Bilharzia. People came running from the village to greet us and we were guided up the hill to a small building which was used as a school, a church and a clinic. We were introduced to our medical assistants who were to be our interpreters and supervisors. Medical assistants are trained for three years and basically to the job of a doctor. In the community they are usually the most qualified, in hospitals they see the majority of patients in outpatient clinics and admit the ones they feel that they cannot treat so the patient can be seen by a doctor.

We soon realised how frustrating Ugandan medicine could be at its worst. Patients would present with fever, chest pain, stomach pain, back pain, malaria and even once fallopian tube pain! The medical assistants would thus obligingly prescribe anti-malarials, two antibiotics, magnesium trisilicate and ibuprofen. There was no real attempt at history or examination and patients who presented with malaria looked surprisingly well. I tried to explain why I was a little surprised to my assistant but he was quite adamant that we would give the patients tablets as that was what they had come for. The clinic lasted five hours, we had had no food and little water all day but we had learnt valuable lesions that would help us to understand the patients we saw when we worked in hospital. We were staying in a mud house which had been plastered, our toilet was a posh hole in the ground up a hill and our shower was an elaborate contraption consisting of an old petrol can and some two by four outside by the “kitchen”.

The next day we walked for an hour through the jungle to get to our next clinic. It had been explained that the reason tablets were given out so freely was because even if the person wasn't sick now they could be later and the clinic was only once every

fortnight. This made it easier to understand but I was still very wary and insisted on at least attempting to examine patients which the medical assistants found quite amusing. Many people on the island had syphilitic sores and vaginal discharges, we saw a baby with polio, venous ulcers, malaria, abdominal masses and many general complaints. It was very difficult to know if the right treatment had been because there were no diagnostic tests and a limited formulary. The ladies on the island cooked us a really typical Ugandan meal to say thank you. We had goat or chicken stew, rice, matooke (a kind of savoury banana and a staple Ugandan food), posho (ground maize mixed with water to a rubbery consistency), beans and Chi tea which tasted like rice pudding!

After church on Sunday we did a short clinic which was nearly abanded when the heavens opened. Rainy season is between March and May so we saw quite a few spectacular storms.

My experience on the island was an incredible learning experience and I don't think I'll ever forget it. The next day back on the mainland we went to health education program in a village called Bukalega. The lady who runs it has been working with the villagers for nearly ten years, she has taught the women how to look after their children and with some input from a GP in Manchester and the book "where there is no doctor" she has begun to teach them how to recognise health problems like complications in labour and sick children. The ladies in the project are now delivering each others babies and they know how to treat common but sometimes fatal conditions like diarrhoea and dehydration. We visited a similar project closer to a large town called Jinja which was set up to support women with AIDS who were shunned by their families. Sally and I did a presentation on how important hand washing is to prevent infection with helminths which are incredibly common - especially in children, who have huge distended abdomens as a consequence. We distributed worm tablets to families and the women were so happy they ululated and sang songs to us.

Hospital medicine

The health system in Uganda is structured so that there are many levels at which a patient can access care. The most basic clinic is a level one health centre with very few facilities, probably run by a nurse. Level two is run by maybe two or three nurses or midwifes and has a dispensary. Level three has medical assistants, nurses, an outpatients department and maybe one or two inpatient beds. Level four has maybe one doctor, medical assistants, nurses, a dental unit, a maternity unit with inpatient beds, delivery suite and antenatal clinics. It would have a larger formulary and may have some basic diagnostic blood tests like haemoglobin and blood slides for malaria. Level five clinics are hospitals with varying facilities but most have inpatient beds, at least one theatre, outpatients, maternity and more sophisticated diagnostic tools like ultrasound or X-ray.
Some clinics are entirely government funded and patients don't have to pay for their treatment. Some are run by missionaries or private organisations and the patient pays an amount towards their treatment and some are subsidised by the government. The hospital we were based at was founded by Irish nuns and is currently 70% government funded so patients pay a small amount or their treatment. It is in a small town called Kamuli but serves a huge population. There are only four doctors in the entire hospital and they cover all of the different departments between them changing every 3 weeks to keep their skills up to date. They have only been qualified for about two years but they have had to learn incredibly quickly as they are the only people available to do all of the surgery and inpatient care. If they don't know how to do an operation and it's an emergency they go away and read up the procedure quickly. One doctor will operate and one will read the procedure from a book.

All four doctors are incredibly dedicated, they live on site and are on call regularly but they enjoy their jobs and want the best for their patients. Dr Titus the superintendent has decided not to treat patients in the "Western way" as they are taught at university because he says more patients die this way in Uganda as they don't have diagnostic tests and don't have time to give specific treatments until one works. As a result they don't know if their treatments are correct as a barrage of drugs is given, of which one will work, but which one? They are just thankful if the patient gets better. Dr Titus is currently trying to obtain funding from the government to buy a simple blood analyser so they can get blood results.All of the doctors took time to teach us, I did rotations in surgery, maternity, medicine and a small amount of paediatrics. I saw so many interesting cases but a few stuck in my mind.

During our time at the hospital a retired surgeon from Wythenshawe hospital visited Kamuli with a paediatric surgeon to do vesio-vaginal fistula repairs. After observing some repairs I assisted in an operation on an eight year old boy for what was thought to be an undescended testicle. The boy also had marked hypospadias and when surgery was done to retrieve the testicle it was found that he actually had half a testicle and half an ovary. Exploratory surgery showed that a uterus and a normal ovary on the other side were present. When the hypospadias was explored it was found to be an imperforate vagina and the penis was actually an enlarged clitoris. This was an incredibly difficult case of intersex, complicated by the fact the child had reached eight years of age before this was discovered and was thought of by his family, friends and village as a boy and by the fact that we were in Uganda with no means of hormonal manipulation to allow him to develop secondary sexual characteristics.

The options available were to create a vagina, reduce the clitoris and remove the ovary/testicle so that the child could function as a female although an infertile one or we could remove the ovary/testicle, repair the hypospadias and send him miles away to Kampala the capital for testosterone injections at puberty. In England this child would probably have been

changed into a girl with extensive counselling and she would probably have had to move schools. At least she would have looked like and functioned as a girl. In Uganda however the boy would have been abandoned by his village and his family if he had been changed into a girl, there is no counselling available and no telling what psychological damage may have been done. However the only option we really had was to leave him as he was, although no he has no testicles and won't produce testosterone so won't develop any secondary sexual characteristics. He won't be able to function sexually as a male and boys in Uganda have a high incidence of suicide in their early teens if they cannot perform sexually. The boy's mother was fully informed of the findings and the potential difficulties to be faced but I wonder how much she really understands. This was such a difficult case and a sad one too so I was very grateful for a fellow medical student who I could talk to and who understood the frustrations that are faced in Uganda.

Not all of the cases we saw were this difficult and lots of patients who were seriously ill before admission recovered quickly. I saw a young boy recover from tetanus with full body spasms and who was unable to eat. One man came in with peritonitis from a perforated duodenal ulcer and was really unwell but refused to have an operation because he wanted tablets to make him better. After trying to persuade him he needed the operation or he would die the patient decided to go home. He came back a couple of hours later feeling so unwell he'd decided he wanted the operation after all and then enjoyed hospital so much when he'd recovered he didn't want to go home!

The ladies who had had VVF repairs had to stay in hospital for two weeks before they could have their catheters out and I was responsible for checking that they were still dry afterwards and that the operation had been a success. Out of fifteen women only one was wet when she was discharged. The women were so happy, they had been abandoned by their husbands and their villages thought they were a disgrace but now they could start

to rebuild their lives again - it was wonderful to see the change in them. One of the doctors described Uganda as a pathology museum and I'd tend to agree. Because vaccination is not yet widespread diseases like polio and tetanus are not uncommon. Patients present late so tumours grow to huge sizes before being diagnosed. I saw a sixty year old lady with a hugely distended abdomen due to an ovarian mass and because screening is poor diseases like cervical cancer usually present when they've become inoperable.

One disease Uganda is really tackling is HIV/AIDS. We went to three secondary schools to teach about proper condom use and why it was so important not to ignore AIDS. Kamuli hospital has been given government funding for antiretrovirals and has set up a clinic registering newly diagnosed patients. They use a detailed proforma to assess what stage the disease is at and what symptoms and treatment the patient has had. The clinic is only in it's infancy and the drugs are still very expensive for a Ugandan, one months treatment costs 50 000 Ugandan shillings and the average Ugandan earns 30 000 shillings a month or less. It was a good way to learn about HIV/AIDS and to see the signs and symptoms of the different stages. AIDS is still quite stigmatised, we saw a man with an X-ray characteristic of TB, he had oral candidiasis, shingles and weight loss but refused to accept that he had AIDS even though he'd had two positive tests. Counselling is made available and actively incouraged especially before marriage but some people inevitably still struggle with the diagnosis. AIDS has had such a huge impact in Uganda, the number of cases each year is starting to slow down but the effect on the population has been massive. About 50% of the population is bevailable and actively incouraged especially before marriage but some people inevitably still struggle with the diagnosis. AIDS has had such a huge impact in Uganda, the number of cases each year is starting to slow down but the effect on the population has been massive. About 50% of the population is under 14 and there are only a small number of people aged between 40 and 55.

We visited a busy hospital in Entebbe near the airport. After the oasis of Kamuli I found it quite hard being in a hospital where everything was crammed into such a small space. We

were greeted very formally by the medical director as is normal for Uganda where every occasion is marked by numerous introductions and formal speeches. We were given a tour of the hospital first and my overwhelming impression was that they had created lots of departments that sounded fantastic but which weren't really what they said they were. Casualty was a triage nurse surrounded by 200 patients waiting to be seen and a small treatment area. They had an orthopaedics department which was a plaster room and the delivery suite only had three beds with no dividing curtains. The hospital did however have a well equipped labatory by Ugandan standards and had a dedicated surgeon because of the high numbers of road traffic accidents that they saw. We saw some surgical patients who had been isolated because they were robbers who had had petrol poured on them and had been set alight for stealing a mobile phone. We also saw lots of paediatric cases as we spent time on the ward, most of the babies and children had malaria. As we were looking around the ward we noticed a 6-8 week old baby lying on the bed by his mother. The baby was very flat and dehydrated so we asked the nurse in charge what he was admitted for and she told us he wasn't even an inpatient, it was his mother who had been admitted. We asked her to put some fluids up and told the mother to feed him more but the hospital had run out of bags of fluid so the mother had to go down the road to the pharmacy to buy some, such is Ugandan medicine.

I did so many other things during my time in Uganda; my husband came out to fix computers at the orphanage where we lived while I was at the hospital. We sat with a deaf boy whose parents thought he was just being disobedient and had left him at the orphanage when everyone else went home for the holidays. We gave him a small football to stop him crying and got a smile and a tight squeeze in return. I talked to boys from a prestigious boarding school about being a medical student in

England. I spent time with six formers from Manchester Grammar School who had come on a trip during the Easter holidays and showed the ones who wanted to do medicine around the hospital. We stayed by the river Nile, slept in four poster beds and ate fantastic steak one weekend and built mud huts and gave out wheelchairs in the villages others. My expectations have been far exceeded and I can't wait to go back when I have more skills and can be of more use. I highly recommend going to Uganda, it was a real eye opener and although sometimes it felt like I was practising medicine in the 1940's I learnt lots as a result. I am a more confident, experienced and caring person than before I went on elective and I even managed to do revision while I was there! I am happy that I have achieved all of my objectives and I will never forget these experiences or the people that I have met. I truly felt like an adventurer. No longer when I think of Africa will I first think of miserable, starving children although that is a reality in large areas in Africa and one not to be forgotten. I will think of Uganda. I shall see huge smiles with bright white teeth, dignified women farming all day to provide for their children, men who are passionate about their beautiful country and hundreds of small, excitable children jumping up and down shouting "jambo, jambo, jambo. Muzungu byeee!!!!"

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