A medical elective in Uganda

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In the summer between graduating from medical school and starting my first Foundation Doctor post in the UK, I decided to travel to Uganda for an elective period. I was keen to experience medicine in a different health care system, particularly in a resource-poor nation.

I spent the first week working with a project in Namuwongo, in the suburbs of the city. Namuwongo Community Foundation (NCF) is a small charity that runs a school, a feeding programme and social work in the slum (see Figure 1). Children from the slum community received free education and a hot meal every day, which their families could not otherwise provide. Social workers visited the community to support the more vulnerable families and offer counselling and training programmes in wellbeing, health, and finances.

NCF also ran a clinic to provide for the health needs of the community (see Figure 2). The clinic had limited resources with only a handful of beds, an examination room and a pharmacy. It had rapid antigen diagnostic tests to confirm malaria, syphilis, and HIV, and was able to dispense antibiotics and basic medications. But without access to blood tests and further investigations, there was a limit to what the clinicians can do for their patients. The clinicians can recommend a patient attends hospital but this is often met with resistance from patients as treatment can be very expensive. People may consult traditional healers first. This is a cultural matter but also with a degree of mistrust in conventional medicine and its association with Western culture. Fortunately, it seemed this clinic had a good reputation within the community, thanks to its connection with the project. Similar health clinics can be seen everywhere in Kampala, providing primary care to local communities. However, these clinics do not appear to be well regulated. Some are not run by fully qualified doctors and instead by nurse practitioners, clinical officers or midwives so the quality of care is variable.

Figure 1. Children at the NCF school. (Credit: Matthew Brearley, Chair of Trustees at NCF)

After spending time at NCF, I started a 4-week placement at Nsambya Hospital, a 'private-not-for-profit' Catholic hospital on the edge of Kampala. I worked within the maternity department and spent time on the labour ward, in the operating theatres, wards and clinics. There was a high proportion of emergency cases, including those having been referred from other hospitals in Kampala. Women were admitted with pre-eclampsia, foetal distress, placental abruption and postpartum haemorrhage, amongst other complications.

I was surprised at the proportion of deliveries that progressed to Caesarean Section (CS) rather than normal vaginal births. I learnt that there is a high prevalence of cephalo-pelvic disproportion (CPD) in Uganda, which contributes to a higher rate of CS's. Previous studies have associated CPD with contracted pelvis (due to protein malnutrition) or adolescent or early

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marriages.[1,2] Hence, obstructed labour is a frequent indication for emergency CS. Furthermore, as a private hospital, concerns about expensive healthcare meant women presented late with pregnancy complications. It is also possible that women do not receive appropriate antenatal care due to limited access, increasing their pregnancy risk. I would have liked to have spent longer to gain a better understanding of these limitations and difficulties.

The antenatal care in Uganda was, in many ways, like that in UK. The Ugandan Ministry for Health follows the World Health Organisation recommendations, aiming for a minimum of eight contacts with the mother during her pregnancy, in uncomplicated cases. There was a great emphasis on diagnosing, treating and vaccinating against infectious diseases which are much more prevalent in Uganda compared to the UK, and included tetanus, HIV, viral hepatitis, parasitic worm infections and syphilis. Other non-communicable diseases were much less common, such as gestational diabetes mellitus and cancers. I saw one patient with endometrial cancer during my placement, which I was assured was quite rare in Kampala.

Moreover, there was greater dependence on clinical examination due to limited technological resources. Obstetric examination was used to confirm the foetal presentation and a fetoscope for determining heart rate, rather than relying on ultrasound scans and Dopplers which are common place in the UK. In these resource-limited settings it was obvious that taking a proper history and carrying out a thorough clinical examination were crucial. Maybe this is something we should reinforce in our practice in the West. Some mothers' care was limited by cost of medications. For example, one mother had a history of deep vein thrombosis but was reluctant to start prophylactic clexane (low molecular weight heparin) injections, putting her at greater risk of venous thromboembolism during pregnancy.

Theatre practices were largely the same in the UK. However, at Nsambya hospital, I did notice a few differences. For instance, it was standard practice to cut out the scar from a previous CS due to the increased likelihood of keloid scars forming in dark skin. It was also common for surgeons to externalise the uterus when closing, to help visualise the wound and identify any areas of bleeding. There seemed to be a small gynaecological caseload and the most theatre time was dedicated to CS's. Often women had already progressed into labour before a decision was made to deliver by CS and this made the delivery more challenging as the uterus was contracting.

Despite lots of differences to the UK, I was surprised by how familiar the hospital environment felt with ward rounds, morning handovers, clinical governance meetings and interns who had been through similar training to myself. This meant after a month I had started to get settled in, just as the time came for my return home.

Figure 2: Health workers at NCF clinic. (Credit: Matthew Brearley, Chair of Trustees at NCF)

I was pleased to find that Continuing Professional Development was taking place. I attended weekly audit meetings where cases of neonate or maternal mortality were reviewed and discussed, to identify areas where there were any oversights or areas for future change. I also attended presentations from residents in training who had just returned from rural placements where they discussed and reflected on what they had learnt. All the interns had to do five case reports during their year.

I am very grateful for the time I spent in Uganda. It was a great opportunity to experience medical work in a different culture and it gave me an insight into the frustration of trying to provide healthcare with more limited resources. I have a greater appreciation for how health needs vary across countries and it has made me want to get more involved in global health work in the future.

References

1. Desta M, Mekonen Z, Alemu AA et al. Determinants of obstructed labour and its adverse outcomes among women who gave birth in Hawassa University referral Hospital: A case-control study. PloS One. 2022;17(6):e0268938. https://doi.org/10.1371/journal.pone.0268938
2. Kabakyenga JK, Östergren PO, Turyakira E, Mukasa PK, Pettersson KO. Individual and health facility factors and the risk for obstructed labour and its adverse outcomes in south-western Uganda. BMC Pregnancy Childbirth. 2011 Oct 14;11:73. https://doi.org/10.1186/1471-2393-11-73