

## RACHATKAGANDO

Rach is a british doctor training in general practice who is spending 6 months working at a hospital in rural Uganda and will be keeping friends and family up to date with things here.

**Feeds:**

Posts

Comments

### HIV services

June 12, 2011 by rachatkagando

The past month has been extremely busy. I somehow thought I would be "winding down" now that I am entering my last few weeks here but instead seem to be getting busier and busier!

I was asked to write some paediatric antibiotic guidelines by the clinical officers and this has been keeping me very busy. There is some inconsistency in antibiotic prescribing for children and so it will be good to try to standardize it a little.

A couple of weeks back we had a case of possible Ebola on the ward. A 5 year old child was admitted and died after a short history of fever and catastrophic haemorrhaging.

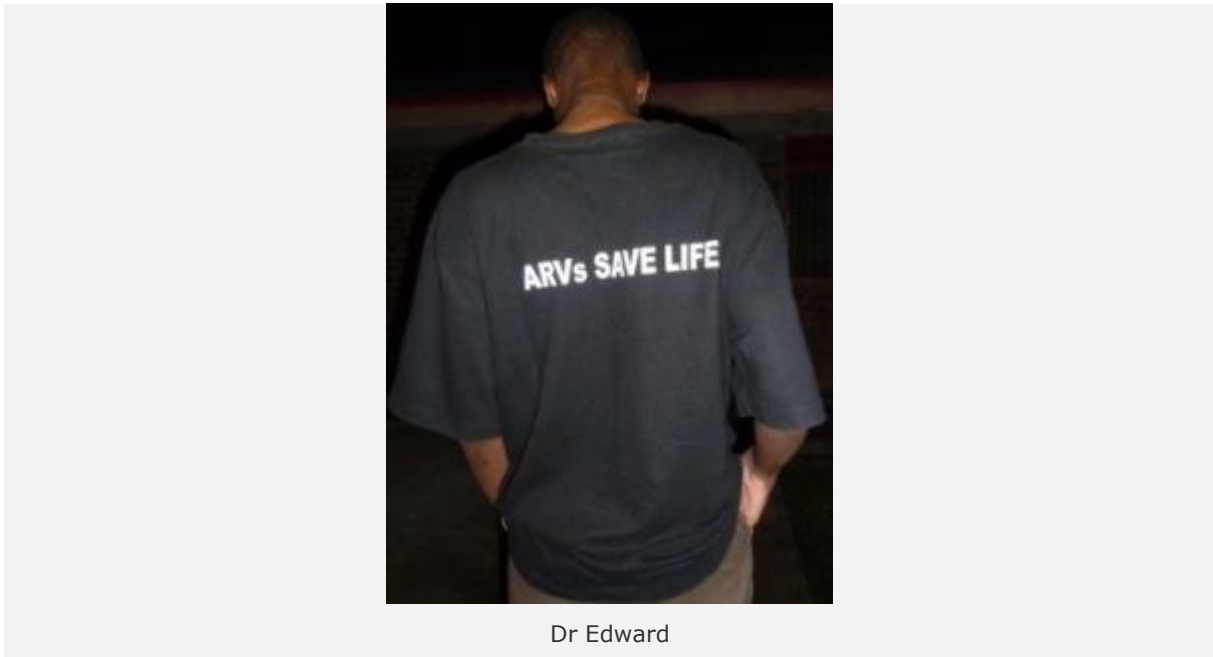


Protective clothing worn when dealing with possible Ebola case (proved negative)

This occurred shortly after posters warning of Ebola and Marburg symptoms had appeared all around the hospital. There have recently been a couple of confirmed cases of Ebola in Uganda (in a completely different area). Ebola is a highly infectious form of viral haemorrhagic fever and causes a lot of anxiety whenever murmurings of an outbreak occur due to its high fatality rate. Blood samples had to be taken from the grieving parents and sister as well as from the child's body. Nurses who had had contact with the child were given a few days off work until initial samples came back as negative from the viral research laboratory in Entebbe. It was distressing to have to

put the parents through this, especially as the results ended up being negative. However, it was impressive to see how a possible outbreak is dealt with at Kagando and all the correct procedures followed.

Much of my recent time off has been spent helping write a proposal and budget for the HIV services here in Kagando which are under strain, with major funders having changed hands. This has resulted in funding for outreaches being cut, so that many patients who were receiving regular antiretroviral therapy are no longer being reached. Many of the HIV clinic staff are hospital employees who do the HIV work voluntarily



Dr Edward

over and on top of their contractual duties and this means that morale is low, with a resulting impact on HIV services offered. Myself and one of the Ugandan doctors, Edward, will now be looking at sources of ongoing funding and considering companies and trusts to which the project proposal can be sent and further funding applied for. The situation in which patients have been started on antiretroviral (ARV) drugs and subsequently been unable to access them is such a sad one, especially as the drugs themselves are free to patients and the patients prognoses so much improved by being on them. The main issue is a lack of resources to reach these patients, some of whom live quite far away. If anyone is interested in giving to the hospital HIV/TB Project, I can send you the project proposal. The easiest way to give is through "Friends of Kagando" Charity([www.friendsofkagando.org](http://www.friendsofkagando.org)) specifying what any donation is for. The HIV Project funding priorities are outreach, investigations for those on antiretroviral drugs (to ensure safe prescribing) and a modest additional salary to staff who run HIV Clinic, currently doing so for no extra pay.



As the end of our time at Kagando approaches, Carmen and I have been reflecting on going home and what we are going to miss here. We leave on the same flight in July and have decided it would really help if our friends could arrange for a large group of small children with snotty noses and holes in their trousers to be at the airport shouting "Muzungu Muzungu, how are you?, give me sweets, give me balloon,

give me money". We are really going to miss them.

Posted in [Uncategorized](#) | [Leave a Comment](#) »

## May update

May 1, 2011 by [rachatkagando](#)

We have quite a number of medical students doing their electives here at Kagando. It is very strange to think it is over 6 years since I did mine. Despite the horrors of children dying, the paediatric ward is still a pretty special place to work and popular with the students. It's nice to see them become more confident in examining children and I have really enjoyed the company and an opportunity to do some more teaching.



The ward has been a bit busier, with two patients to each high care bed. There have been a couple of babies recently who I'm fairly convinced have congenital heart defects. We can't scan them so it is purely a clinical diagnosis. It can be difficult to get a chest x ray as there is no portable oxygen. Eventually these children need referring to Kampala for definitive treatment but deciding when to refer is really difficult as they are likely to die on route. On the other hand, you don't want to deny them the chance to have surgery. Spotting the window of opportunity to refer is one of the biggest challenges we have, especially as the

parents are often so resistant to referral due to transport costs. We have a hospital ambulance but not many people can afford this.

We had a young child referred from the Congo with a referral note written in French. I just about managed to decipher that a laryngoscopy had been done and a foreign body visualised in the windpipe. The history and clinical picture seemed to fit and the child was in respiratory distress so we repeated the laryngoscopy but couldn't see anything. Assuming the object had been dislodged further, I referred to Kampala, a long way from home for the parents. I write my mobile number on all referral letters requesting an update to help inform our referral practice. I don't always here back but on this occasion received news that the child had been successfully treated for a chest infection, having had repeat laryngoscopy with nothing visualised! Children here spend a lot of

time playing unsupervised in the outdoors so it can be difficult always to get an accurate history! Although it had cost the parents a lot of money, I don't think I could have made another decision, but it is good to get referral outcomes and consider whether referral was appropriate and timely. Another child we referred for laryngoscopy a month previously had had a fishbone stuck in its trachea, having initially thought to have had Croup.

All sorts of patients seem to find themselves on the surgical ward, many of them paediatric. Surgical and paediatric wards are opposite which at least allows for easy referral to one another. I am not used to children being anywhere but a paediatric ward and there are times when I think the patient should be moved, like in case of severe burns. One of the Ugandan surgical doctors feels very strongly otherwise and so I have not pursued pressing my point of view, acknowledging that I am a guest here. It can be ethically very difficult though, especially when a small child with burns does not receive fluids prescribed.

A child with a short history of facial swelling was referred from surgery, having not responded to antibiotic treatment. After some discussion, I decided to refer to Mulago due to the lack of improvement and non-infective features. I had concerns about airway obstruction if the swelling was to worsen. It would be very unusual for a child this young to have a Burkitts Lymphoma but the appearance was classic and I was not happy to run the risk with such a treatable form of childhood cancer. I would rather refer and discover it was infection than have a child with a preventable airway obstruction, too sick to transfer.



We continue to have fun in amongst the hard work and sad situations. It was announced in Chapel one morning that there would be "tribal" dancing the following Thursday and that the fifth "tribe" to take part would be the Muzungus. We conscientiously prepared a dance, deciding that Scottish dancing might work, only to find, after giving our "performance", that none of the Ugandans had prepared anything and they had had one over on us!! Anyway, this led to a Scottish

dancing evening, led by Dave (the surgeon) and Helen (his wife). Watching the Ugandan nursing student's dance "Strip the Willow" provided much amusement.

Another benefit of having the medical students here is that it has made it easier for us to get away when we have time off, sharing the cost of transport and getting to know them at the same time. Kagando is really quite remote, so it is a logistical challenge planning to go anywhere!



Lake Bunyoni

Recently we have had breaks in the Crater lakes, Queen Elizabeth National Park and at Lake Bunyoni (photographed) near to the Rwandan border. Last weekend, we enjoyed a great game of volleyball with some doctors from Mbarara and I managed to come away with huge bruises on my wrists.

The realities of life here are stark. One mother on the ward, whose baby is 3 months old and not much more than her birth weight (though HIV negative), wants to remain on the ward, fearful the relatives will send her to a witchdoctor when she leaves. They blame her for not being capable of giving birth to a healthy child. She has four healthy children from a previous marriage but the relatives cannot know this, since the husband is unaware. The mother is scared if she goes to the witch doctor the child will certainly die. Consequently, we think she is not feeding the child regularly enough so as the weight stays down. We can't be sure of this, and want to refer her to Mulago since the child is desperately thin. However, there is no money for transport as the mother is financially dependent and the relatives have given up on the child, believing the little girl will die and the money would be better spent otherwise. Last week we decided to give a short trial of antiTB treatment, to see if she gains any weight. It feels like a desperate situation, but not an uncommon one.

We have now begun mortality meetings on the paediatric ward. It has been a challenge convincing people that the intention is not to attribute blame but look at system loopholes. The first couple have gone well and led to nurses being encouraged to request a haemoglobin if they think a child is pale, without having to wait for a doctor.

There are many superstitions here surrounding twins. I came to the ward one morning to discover there had been a death overnight. It transpired another child on the ward was this child's twin. The mother's disposition must have triggered me to ask whether she was aware of the other twin's death, and it turned out not. The relatives had taken the child for burial, allowing the mother to believe it was still being treated in a sideroom. There is a strongly held belief (which appears to be upheld by nursing staff too) that if the living twin hears the mother's cry for its dead sibling, the living twin too will die. Unhappy about the situation, I spoke to the senior sister who broke the news very gently but then dragged the mother away from the child in order her cries were not heard. The medical staff find themselves having to carefully balance what they know to be true of medicine with strongly held cultural beliefs.

Yesterday, for the first time we ran out of appropriate blood. I had a newly admitted baby with an Hb of 3.6 (severely anaemic) on the ward and no blood which matched its group (O negative). The parents were not matches for the child and the only hope was to find a universal donor (someone with Group O negative blood). One of the medical students thought she was O negative and after donating an armful of blood, was discovered to be O positive! I was getting quite desperate and asking everyone on the compound, eventually discovering my neighbour, the surgeon, was O negative and willing to donate. If you are a universal donor at Kagando then you can certainly save a life (the only downside being you may have a huge needle stuck in you on a regular basis).

We have made a big push for doing regular observations on all the high care patients on paediatric ward and one problem we have is lack of enough working pulse oximeters. I am going to look into the cost of another rechargeable one for the ward (batteries are often not replaced) and see if I can set up a "Justgiving" page to raise some money for one. I shall post details on here.

For now I am off to make chocolate panackes with the Nutella I joyously discovered in a Kabale supermarket!! I hope you have all enjoyed the Royal Wedding and a patriotic long weekend. It did look fabulous!

With love and best wishes, Rach x

Posted in [Uncategorized](#) | [Leave a Comment](#) »

## Outreach etc..

April 5, 2011 by [rachatkagando](#)

It has been a busy month, helping to coordinate a teaching programme run by visiting doctors, getting more involved with outreach, the arrival of my lovely housemate Victoria, teaching midwives in the nursing school and the patient numbers generally increasing on paediatric ward.

Carmen (one of our occupational therapists) told me they were seeing a lot of general medicine on their disability outreaches and felt a doctor would be useful. The first time I joined, it seemed just about every child had a chronic ear infection being treated with herbal medicines. Some were severe with speech affected and large eardrum perforations. One problem on outreach is that I don't always know the right referral pathway. Invariably I will have only one interaction with these patients so need to give the right advice. It is good if we can give a patient the date when a surgical camp taking place at Kagando so they can attend and receive the right treatment. We ask village health coordinators to note down patient details so we can liaise with them as camps approach or as we find out more information about appropriate referral. This week there is a plastic surgeon here from Kampala and later in the year orthopaedic, ophthalmology and ENT surgeons arrive. They obviously want as many patients as possible so it is good to recruit from outreach clinics. Outreach provides a good change from the ward and the scenery getting to these more remote villages (best appreciated on a boda boda) is truly stunning. Within minutes of arrival, we are cinema. It is difficult to obtain any privacy seeing patients in these settings so it's important to be sensitive about potentially stigmatizing conditions. I almost began discussing my suspicions of leprosy in a young woman with an isolated nerve palsy and skin changes before realising the error and taking her into a back room. The back room is usually the bedroom of someone's house or drug store so not the most appropriate place for a consultation.

Last Thursday we saw 31 patients during a morning outreach. It was nice to do something a bit more like General practice at home and I was pleased to be averaging at 8 minutes per patient!! ( – ok, so there was nothing wrong with some of them except wanting to see the Muzungu!) The variety of conditions is enormous, from children falling behind in school to Filariasis to uncontrolled Epilepsy.

A few weeks ago we had a case of tetanus, (secondary to flea infestation of the toenails) in an 11 year old boy. Just the sound of another child crying made his entire body go into painful spasms. He got the best care we were able to give, including infused magnesium but we had no antibody available. It is sad to see such severe and preventable illnesses still occurring. Most children in Uganda have their Diphtheria, Tetanus and Pertussis vaccinations at 2,3 and 4 months of age just like in the UK, so tetanus should be rare.

I came back to writing this blog a few days later and sadly the boy with tetanus died. Since then we have had another case of tetanus – in a neonate born to an unimmunised mother. At one stage we lost intravenous access and the baby went into continuous spasms, one of the most disturbing clinical situations I have witnessed here. When we regained access the pupils were unresponsive (usually indicating brainstem death). It was hard to decide whether to withdraw care at this point as there was a chance the lack of pupil response was due to medications. We continued care. In the morning I was amazed to find the child had survived the night and its pupils were again reactive – it's brain was functioning. This glimmer of hope allowed me to believe the child might survive against the odds but unfortunately she also died, five days into admission. I found myself wondering if we had done the right thing in keeping the child alive for 5 days. Tetanus is a horrible illness as the spasms it produces are painful and the child fully conscious. It has a mortality approaching 90% even when optimal treatment is available. But you have to try.

Carmen, Iris and I had a relaxing weekend away for Carmen's birthday and returned to Kagando for an afternoon of cake and games. The "chocolate game" and particularly watching Marvin, a Ugandan doctor's exasperation as someone else threw a six and he had to give up his turn – proved great antidotes to events of the week.

My new housemate Victoria, a surgical trainee from Bristol, arrived two weeks ago. It is good to have company in the evenings and be able to cook together, discuss cases and plan time off! On Friday we were both on surgical ward when two patients involved in a head on motorcycle collision came in. One had multiple leg fractures, the other a severe head injury with facial fractures, intracranial bleed and blood hosing from his nose escaping down his windpipe. We needed to stop the bleeding and, given the lack of sterile gauze, considered that tampons would be a good option for packing the nose.

We later discovered there was another patient in a worse condition. We found him on a mattress on the floor in theatre, staff there struggling to know what to do. He had multiple chest and head injuries. At one stage we ran out of Mannitol (a drug used in head trauma) and had to make the unenviable decision which patient to give the last bottle to. We gave it to the more stable of the

two with head injuries as we didn't think the one found in theatre would survive. He died 10 minutes after that decision was made. The other two remain stable.

The mosquitoes are thriving now it is wet season and I keep finding larvae in the kettle, when washing my feet and washing dishes. I am just thankful not to have had to resort to showering under a sieve yet (unlike a friend who had bloodworms coming out of her shower). There are more positive malaria blood smears on the ward and more bites on my ankles. Last week, whilst walking around the house during a power cut, it dawned on me I was no longer afraid of creepy crawlies. That said, if a cockroach gets into bed with me like one did with Carmen last night, I may feel differently...



Cockroach with sweet tooth

As ever, it is wonderful to hear from you. I'm sorry I often don't get to reply individually. (I really could be sat in front of this computer all day with the connection as it is.) Any bits of news are lovely to get, so please keep them coming. I shall be really happy to hear from you.

Love and best wishes,

Rachel x

Posted in [Uncategorized](#) | [Leave a Comment](#) »

## Hair "Saloon"

March 9, 2011 by [rachatkagando](#)

Carmen had booked an appointment for us at the hair "saloon" in Kasese. We left Kagando early in order to arrive for our "appointment" at 8. I had been called at 3 in the morning to see a child on the ward and was thus exhausted. We arrived fairly promptly (having only had to swap taxi's once for one which was not trailing its exhaust pipe) and waited for an hour before asking if anyone was coming to see us. "Yes they are coming," was the answer. I should know by now that this can really mean anything. There is no point in trying to get people to be specific with time. You just have to wait. By 10 o'clock someone had at least left to go and buy the hair

extensions. We were each given a pillow to sit on and the (very long) process began. I was so tired at one point I nearly fell asleep but this is difficult when you have three women playing tug of war with your hair and paying little attention to any suggestion you might be finding it painful.



Kasese Hair "Saloon"

Six hours later Carmen and I stood in front of the mirror to find two rather wild looking creatures staring back at us. We think we look rather "alternative" but here are told "now you are smart, proper African lady". So here's what we look like....



Today I spent all day doing a ward round as I have some very sick patients in high care. One of them is a 2 year old with such profuse rectal bleeding that we have to consider a viral haemorrhagic fever (Marburg, Ebola etc), though the child is not bleeding from anywhere else. I suspect it is Typhoid. I asked one of the surgical doctors to review and he began asking whether the family eat hippo or monkey meat. Monkeys can transmit viral haemorrhagic fever and apparently Anthrax can be contracted from eating hippo meat. Not questions I have had to consider asking in my GP training back home!!

Today David and Helen arrived back from a month in England where they had been visiting their family. David is a consultant urologist from Scotland and his wife Helen teaches here at the primary school. It is really good to have them back and to have neighbours again! They have brought another surgeon, Rob and his wife, Shani, with them and will be doing a urological camp over the next two weeks. The camp is publicised over local radio with all those who might be

suitable for surgery (eg. people with catheters, urinary incontinence etc ) encouraged to come for assessment. The surgery during these camps is free so patients come flocking!!

I am on call tonight but hoping to get some sleep as I am once again exhausted! The other night as I got out of bed to see a patient and braced myself to walk down to the hospital in the pitch dark, I took a moment to look up at the stars. I know it sounds naff but they literally took my breath away. There is no light pollution and the power had failed so the stars were particularly awesome.

Love to you all. Rach x

Posted in [Uncategorized](#) | [1 Comment](#) »

## Jungle CBD!

March 3, 2011 by [rachatkagando](#)

Yesterday afternoon all the doctors here sat down in the boardroom to discuss issues relating to clinical services. I offered to take down the minutes and thankfully just about got the gist of everything that was said! Hotly debated was the issue of junior doctors being expected to act as “heads of department”, taking on board managerial responsibilities in addition to their clinical ones. The junior doctors, who are equivalent to second year qualified doctors back home, have huge responsibilities heaped on them, far more than doctors at equivalent stages have in the UK, both clinically and managerially. This is one reason we are trying to encourage regular CME (educational) meetings. The aims of CME are to ensure continued learning for doctors, to provide a forum to safely discuss case management and share the weight of these huge clinical responsibilities.

Today I got the student nurses to sign up for resuscitation training. They are very keen and remind me of how keen I was as a medical student once upon a time! The nursing school is large with only a small number of tutors so the students really lap up any small group teaching offered. Catriona, the anaesthetic registrar from UK allowed me to nab some material on her laptop from the resuscitation council which I can use for teaching. Most of the sessions will be on the Mzungu resus dolls though! I am hoping the sessions will be fun and help to increase their confidence in an emergency.

Simon (GP from UK) and I sat down (during a thunderstorm!) and discussed a patient’s case in full today and made it into an assessment for my eportfolio back home. It was good to have some time for reflection as a lot had happened on the wards in the last six weeks and discussing one case in full brought out many issues for me. I don’t think the Ugandan doctors are into reflective practice so that is one way in which we differ!

I will leave you with a picture of the malnourishd twin we resuscitated for 2 hours on Sunday. He is looking rather grumpy as was rudely interupted from breastfeeding for this photo.



Posted in [Uncategorized](#) | [Leave a Comment](#) »

## Week off work with Ruth & Andrew

February 28, 2011 by [rachatkagando](#)



**Murchison Falls**





Rwenzori mountains

Posted in [Uncategorized](#) | [1 Comment](#) »

## February Post 2

February 28, 2011 by [rachatkagando](#)



Giant Lobelia

So it's been a while since I updated you. Internet is exa



Tracheostomy Baby

speratingly slow which means I must still have European expectations.

The past three weeks have come with highs and lows.

Friends, Ruth and Andrew came out and we spent a packed week visiting Murchison Falls in the north followed by three exhilarating days trekking in the Rwenzori mountains. Ruth was delighted to at last tick Giraffe off her list of wildlife to see on safari and we all enjoyed the spectacular Murchison Falls themselves – from above and below! We took the more adventurous route back

along Uganda's western border with views across Lake Albert towards Congo, having to turn back in one place as the road was impassable. It was interesting to drive through areas which would have been heavily affected by LRA (Lord's Resistance Army) activity only a few years back. It all seemed very peaceful now but the inhabitants have lived through such a lot. During the height of LRA activity, mothers used to travel at night with their children to the hospital in Gulu, where the quad was used as a safe place from which children were less likely to be abducted and forced into becoming child soldiers.

The mountains were beautiful, rich in unusual plant (see giant lobelia photo) and birdlife with rushing rivers spanned by flimsy little bridges and offering plenty of opportunities for wild swimming! The week was a real high point and it felt somewhat nostalgic for Ruth and I to be back in Uganda as we had both spent our electives here six years ago. Uganda has changed a lot in that time and Ruth could hardly believe that all the dirt roads which used to turn our clothes red were now surfaced and had crash barriers!!

I returned to Kagando to find little Edwin (the child who had emergency tracheostomy in January) very well and fit for discharge.

I have seen a spate of children come in moribund with severe malnutrition and dehydration over the past few days. The worst case was a 1 year old who weighed only 3kg and died 16 hours into the admission. I find it difficult when a child who we have spent a lot of time trying to resuscitate (and at first looks like they might survive) succumbs. These children have such suppressed immune systems that they often die due to infection. Yesterday, a younger child was admitted in a similar state. She is 1 month old and on first glance I wasn't sure if she was even still alive. For the medics amongst you, she was gasping at a rate of about 5 breaths per minute, had a heart rate of 30 and a blood sugar which I'm sure would have been off the scale had we not run out of testing kits. Anyway this one has a real fighting spirit and did well with some cautious fluid resuscitation and two hours of bag and mask resuscitation, which is exhausting even on a tiny child like this! We tried to intubate her but she was having none of it – a good sign. She eventually started breathing for herself and was doing well this morning and even tolerating NG feeds. A big challenge in these children is finding a vein through which to give fluid. If the child is not so sick you can and should use a nasogastric tube but children in this kind of state need intravenous fluid for resuscitation. We often try the scalp as these veins are more visible in severe malnutrition. I have given fluids through placing a needle directly into the tibial bone on a few occasions now and find it useful in buying me time to find a vein. I had never done this in the UK apart from being taught on chicken legs on resuscitation courses back home. It takes a bit of pressure to insert and so you have to be careful not to go straight through into your hand which could be a bit of a disaster in this setting.

The general impression is that HIV is on the increase amongst children here. The prevalence is not as high as in northern Uganda where the history of conflict has led to high levels, with as many as nine out of ten patients on a medical ward testing positive. There is still a lot of stigma surrounding HIV and fear about partner disclosure even though testing is confidential. Nurses on my ward are visibly embarrassed to ask if the mother has been tested, especially when she looks

educated. My approach is not to differentiate but to ask every mother about her status, thereby getting the nurses used to asking and the patients used to hearing everyone being asked as standard. Prevention of mother to child transmission is a key area for promotion here as the guidelines have recently changed and clear messages need filtering through. WHO guidelines now say that HIV positive mothers in developing countries should continue breastfeeding for a minimum of 12 months. This is because child mortality when the mother stops breastfeeding is higher (due to diarrhoeal diseases) than that if the mother continues to breastfeed despite the risk of transmission.

Rapid detection tests for malaria (RDT's) have arrived at Kagando, funded by a US charity. These are extremely sensitive and remain positive for two weeks even after treatment. Very few tests have been positive and this has allowed us to stop treating so many children presumptively. Since fever does not necessarily equal malaria, every child that comes my way is getting an ear and throat examination! I am sure there are some simple ear infections kicking around and am determined to find them!!

Carmen and Iris, occupational therapists from Germany, and I have become good friends and colleagues. We are neighbours so eat together a lot of the time. I have even been remembering some of my German from school days. After finishing my rounds, I make a list of all patients I feel are appropriate for them to see. These include children in recovery stages of Malnutrition (invariably developmentally delayed) or Meningitis and children who have Cerebral palsy. When I refer a patient too early they let me know and this is helping me to understand at what stage a child can usefully partake in therapy. They also do play therapy on the ward once a week when the mothers can be seen shoving the kids out of the way as the paper and crayons appear!

Simon, an experienced GP from England has been here for a month and it has been good to be able to discuss cases with him. His GP experience as well as experience having worked in Kenya has been invaluable. He has agreed to act as a clinical supervisor while he is here and although I make most of my decisions alone, I am relieved to be able to discuss a difficult case with him. We are even planning a CBD this week (medical speak – sorry!)

We have reintroduced CME (continuing medical education) evenings at Kagando. Gradually more people are attending which is encouraging. Last week I presented a case of a 3 year old girl with a space occupying lesion (mass) in the brain and a heavy worm infection. It was an interesting case to discuss as although the most likely causes were meningitis and cerebral malaria, the child had never had fever, raising the possibility of an ectopic worm infection (worms in brain). There was no possibility of getting a CT scan and this made it difficult to decide when to stop treatment. It was useful to discuss the case as a group and we were able to come up with a shared plan to slowly reduce the steroids and anticonvulsants and see what happened. She has done well and will (hopefully) come back for follow up in one week.

After discovering some resuscitation dolls gathering dust in someone's house, Catriona, an anaesthetic registrar from England, ran some resuscitation training for the doctors this evening. The paediatric nurses are keen to have some resuscitation training as well and so I have agreed to run some small group sessions with them over the next couple of weeks. Meanwhile the Muzungu

dolls (which should really be painted brown) are keeping me company in my house and causing a little confusion amongst the children who are always popping by.

Some friends of mine from the DTM&H course have now begun working at a hospital about 3 hours away from Kagando . It is good to be able to call one another on our Ugandan for a general catch up and sometimes to discuss a case. It is strange thinking how far flung everyone from that course is now. Every so often when I have internet success I can logon to the facebook DTM&H group and join in with the virtual "self-help group"! I have this clinical problem in Malawi....what do you think?! I am in charge of a health programme in Congo....how do I monitor progress?! Does anyone know what this rash might be?! It is quite nice to be able to support one another like this – and ever so slightly odd.

Anyway, I have will leave you with some photos to try to entice those of you who were considering a visit...

With love and best wishes,

Rach x

Posted in [Uncategorized](#) | [2 Comments](#) »

## Some photos

February 5, 2011 by [rachatkagando](#)

Entrance to Hospital



My Birthday cake (all gone!) – with elective student George and Dr Marvin

Kasese Sunset



Posted in [Uncategorized](#) | [1 Comment](#) »

## Edwin

February 5, 2011 by [rachatkagando](#)



7 month old Edwin following emergency tracheostomy

Posted in [Uncategorized](#) | [1 Comment](#) »

## January

February 2, 2011 by [rachatkagando](#)

Greetings to you all from Kagando! I hope you are well and the cold weather isn't creating too much havoc in 2011!

I arrived here safely on January 13th, a week after scheduled as I was sick and had to postpone my flight! I have been here just under three weeks and am starting to feel settled & get stuck into work on the paediatric ward. It looks like I will be able to spend time working in outpatients and in the paediatric HIV clinic as well which runs one morning a week. At the moment, just getting to grips with the main conditions seen on the paediatric ward and learning everyone's names is enough to cope with! As to my working week –it is pretty much 9-5 Monday- Saturday unless I am away for a weekend. I am on call one weekend in about four (for paediatrics and medicine). The scenery and wildlife is a real antidote to work, with the backdrop to Kagando being the Rwenzori foothills which make up the border with Congo, about 20K from here. Having had about three days off since arriving I am really looking forward to the arrival of Andrew and Ruth next week and to doing some trekking in the Rwenzori's. On Saturday myself and an occupational therapist here, Iris, spent the day at a lodge which looks out over the vast savanna of Queen Elizabeth National Park. It felt rather hedonistic to be there given the widespread poverty all around and although my head dictated I needed time off there was definitely something more visceral that didn't believe this was how the world should be.

Soon after arriving I was told that the doctor in charge of the paediatric ward was leaving the following day and the medical director hoped I would "fill the gap". Having spent my elective in Uganda, I had been half expecting some such nice surprise but I still felt like running a mile at the prospect of being medically in charge of the ward. Thankfully, a very competent Ugandan intern is currently also working in paediatrics . She headed to Kampala for a week's leave a couple of days after I arrived & so there was no avoiding this baptism of fire. As I carried out my ward rounds,

the realisation that the tropical medicine I had learnt in Liverpool wasn't going to smoothly translate into clinical work here soon hit me. The lack of resources and financial constraints here massively restrict what we can do, whatever knowledge we possess. They dictate whether a child receives their prescribed drugs ( "out of stock" regularly appearing on treatment charts without any request for an alternative) , whether a parent stays on the ward or leaves when their child is half-way through treatment, whether children are brought for follow up, whether investigations are done, whether you can be sure of the result when they are, whether children come to hospital in the first place and whether when they are brought it is in time. In most cases, my treatment plan has to be a compromise due these constraints. If I don't compromise then my treatment plan is unrealistic & will understandably be ignored.

Six year old Costa was in hospital for two weeks with severe hip pain – a presumed sickle cell crisis. For the first week his "attendant" (a family member who carries out nursing care and provides the patient's food) was a 14 year old brother. Over the second week Costa had no attendant with him and I frequently found him in tears. His pain was severe but we were unable to treat with anything stronger than paracetamol and diclofenac (morphine is rarely available, though the palliative care department are in negotiations with Hospice Africa on this). He would take big handfuls of medication on an empty stomach unless other sympathetic attendants donated him food. Costa's father eventually turned up and was pressing for Costa to be discharged. His father was unable to pay the hospital fees so Costa stayed while his father went to get the money. During this period his pain worsened and he stopped walking again. I had assumed he had been receiving oral medication while he waited but in fact his treatment chart had been in the cashier's office and he had received nothing for 2 days. He was now in need of further IV antibiotics (we had been unable to exclude infection so like in many cases here, had to cover both diagnostic possibilities: sickle cell and septic arthritis), but the father point blank refused these (understandably fearful of further charges). If we insisted on further hospital treatment the father would leave the hospital with Costa and not return, so I explained the discharge medications to the father, requesting he return in a week for review. The hospital social worker agreed to visit the home if Costa did not come. Costa needs a test to confirm sickle cell anaemia. It will be a challenge persuading them that diagnosing this is a priority when clearly they have barely enough food to go round. I am not even sure myself that the diagnosis is a priority given this family's circumstances. Nevertheless, I have suggested he return for this test.

It is difficult to know how to act in a child's best interests and be their advocate in a setting where poverty is so pervasive. I think here we often assume that because a parent wants to be discharged early or are reluctant to come for follow up that they are being irresponsible when in fact they are acting in the collective best interests of their children – including the 8 or 9 others at home. I started trying to build up a picture of the situation by asking how many children there are at home and whether anyone is employed. It is difficult to get an accurate social history however as either the nurse translating thinks I am being frivolous and doesn't ask the question or the parent gives the answer they think is most likely to result in a financial handout. I now tend to go on their clothes and whether or not they speak any English as indicators of the level of poverty.

It has been really good to have Dr Dora back on the ward following her leave. It helps having someone to talk with after an unsuccessful resuscitation or when a child is deteriorating and I don't know why. She is vastly more familiar with the common paediatric diseases here (malaria and typhoid – which present similarly) as well as the Ugandan treatment guidelines (which often differ considerably from information I was taught on the DTM&H in Liverpool ) and is a lot faster than me at seeing patients! I am told that once you have experienced single handedly seeing 180 kids a day you become quick. I just hope I have a 5th gear for when the wet season hits next month, bringing diarrhoea. I have to keep reminding myself that though I have been qualified a few years I am still new to medicine in this setting. Dora found my concern about a 10 year old with a slow heart rate mildly amusing, advising me this was normal physiology for a kid from the mountains who ferries large quantities of water up steep slopes.

Children are admitted with a combination of fever, cough, convulsions, abdominal pain, diarrhoea & vomiting, difficulty breathing, unconscious or occasionally and tragically, already dead. Malaria and typhoid, the two most common endemic conditions present very similarly and are notoriously difficult to differentiate between, especially when the history is given through a translator. At the moment I need a nurse to translate and although they are skilled translators I find it hard to pick up on the subtleties of a parent's history without having their language. It is not uncommon when asking "how long has he been unwell?" for a two minute heated discussion to take place but for me to just be told "quite a while". I am learning who the best (& most enthusiastic) translators are and becoming a little picky in who I ask!!

Clinical officers (who work like doctors but would probably be called "physician assistants" in the UK) see patients first in outpatients , decide on whether to admit and often commence treatment to cover all possibilities – ie. a broad spectrum antibiotic and treatment for both malaria and typhoid. Although this is frustrating from a clinical and a public health point of view I can see why they do it – for each individual child it is probably the safest option. Differentiating between malaria and typhoid is difficult because blood smears for malaria parasites are invariably negative. This may be due to parents buying oral quinine and treating for a few days whenever a child has fever or because the laboratory staff are under too much pressure. Positive blood smears are not diagnostic of malaria as the presence of malaria parasites may simply indicate previous malaria exposure. Therefore it is important to have a flexible working diagnosis. Certain questions and signs can help. For example, if a child has been started on adequate dose quinine for more than 3 days in the community and has only deteriorated, the likelihood of typhoid is greater. A child with fever and severe anaemia, jaundice and an enlarged liver is more likely to be suffering from malaria. There are very few things which give a definite diagnosis and most of my decision making here is based on probabilities rather than certainties and on watching a child's progress.

I have felt frustrated that the hospital charges patients and that these charges can be disabling to families and discourage health seeking behaviour. Kagando does have international funding but still needs to charge patients in order to continue its work. Alternative healthcare consists of herbalists, small private healthcare clinics (expensive and variable in quality) and government hospitals which are meant to be free but charge for many medications and often refer to Kagando because locally, they often have little in the way of medication or medical staff. (A Medical student

told me that over 50% of medical students start out medical school with the intention of leaving Uganda once qualified and well over 50% do leave). Kagando has a very good reputation among locals as it is relatively well resourced in comparison to the alternatives – we currently have eight doctors. There is a compassion fund available for patients who really cannot afford to pay although in my brief experience it seems there is often a delay in referring patients to it.

In my first week I was called to a child who had just come in having been continuously fighting that had stopped breathing. I asked for resuscitation equipment and realised I was the only person with any sense of urgency in this situation as the nurse slowly walked off to have a look. As the heart stopped beating I asked someone to take over with chest compressions as I continued on the breathing. As I watched a nurses' arm movements make no indentation on the chest wall whatsoever, I realised I was on my own. I called over a German occupational therapist who happened to be on the ward because in my panic, I was failing to communicate effectively with the Ugandan nurses and instead just feeling frustration. Iris, who had no medical experience took over with the patients' breathing while I continued with chest compressions. A large crowd stood around watching and eventually some adrenaline was brought & given. Another doctor arrived fifteen minutes later and told me to give up as the child was dead. I lifted the dead child from the hard floor (the only surface on which adequate chest compressions are possible) onto his bed. Ten minutes later, the mother of a child in the same bed as the one who had just died (two per bed) called me over to her child who was being treated for cerebral malaria and had started convulsing. He soon stopped breathing and as I reached for the resuscitation equipment and wondered whether this could really be happening, I heard wailing from the mother, who had just watched the very same equipment fail to resuscitate the other child who lay covered in blankets further down the bed. This resuscitation was initially successful but despite intravenous treatment, the child also died two days later.

One extremely sick child admitted that week is making a good recovery. Edwin is 7 months and had a three week history of breathing difficulty coming in "attacks" and weight loss. He was in acute respiratory distress, with the most massive chest wall recession I have ever seen (even on teaching videos!) with only 1 in every 10 "breaths" resulting in air entry. He had acute airway obstruction, although I did not know what was causing this. All I could see was a mass of tissue to one side of his throat – it didn't look particularly inflamed and there were no signs such as fever to help differentiate between a tumour and an abscess. Having aspirated quinsies in cooperative adults, I tried to aspirate it but this was impossible with an uncooperative 7 month old. The anaesthetist was initially not keen to get involved and felt the child needed specialist ENT attention. This was only available in Mbarara however, a 5 hour journey away and the family had no money for transport. Either we waited for the child to stop breathing and then intervene or we were proactive and tried to prevent that situation occurring. Edwin had already been treated conservatively with steroids and antibiotics and his breathing had only deteriorated. After desperately scrabbling around in theatre for a while, we found a mini tracheostomy set which no-one knew even existed and then I went and managed to persuade our surgeon to operate and the child's chest wall went from completely collapsing with each breath to normal. Good nursing care, meticulous suctioning and careful nursing handover has meant this child is doing well. He looks at me with deep suspicion as I approach him with the suction tube. At surgery, we discovered he had

a retropharyngeal abscess which we were able to drain. He is doing well and we hope to remove his tracheostomy tube later this week. Edwin is my ray of sunshine on the ward right now as he seemed to represent hope in a week that really lacked it.

Excitingly, I have now moved into my "own" house here and it is really nice to have some space and be able to make it home and put a few things on the walls. I still need a stove and so am currently eating at the guesthouse which is good for company! My house is much larger than I expected with a beautiful garden, running water, electricity and even a shower (which towards the end of the day has warm water!!) I make sure I keep a torch close at hand though as the electricity is very much on and off though currently more on than off 😊 .

The big thing in Uganda right now are the elections (5 yearly) which are held this month (18th Feb) and we are all hoping and praying that they will be peaceful.

Thank you all for your support by email, post and phone call which has really been totally invaluable.

With very much love, Rach xxxxx

## Map

January 8, 2011 by [rachatkagando](#)



So here's where I will be spending the next (just over) six months. If you look to the southwest of this map, you will see there are two smallish looking lakes, Lake Edward and Lake George (named after Queen Victoria's offspring) in that region. Kagando Hospital is just north of these near to the foothills of the Rwenzori mountains which make up Uganda's western border with the DRC. It is a very beautiful spot...

Posted in [Uncategorized](#) | [1 Comment](#) »

## Hi all

January 8, 2011 by [rachatkagando](#)

Hello friends and family. So I'm just starting to experiment with "blogging" – a big step for a



technophobe like me. I wanted to load a friendly pic of myself so none of you would forget me! I'm going to miss everyone but am looking forward to what will I'm sure be a challenging and rewarding time at Kagando. With love, Rach x

Posted in [Uncategorized](#) | [Leave a Comment](#) »

## Hello world!

January 8, 2011 by [rachatkagando](#)