Reflections on an elective in Kenya

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Hijiri is interested in Paediatrics. She is one of a group of UNSW students raising funds to assist children and their families at Kenyatta National Hospital in paying for medical treatment.

"*In Africa, you do not view death from the auditorium of life, as a spectator, but from the edge of the stage, waiting only for your cue. You feel perishable, temporary, transient. You feel mortal. Maybe that is why you seem to live more vividly in Africa. The drama of life there is amplified by its constant proximity to death.*" – Peter Godwin. [1]

Figure 1. *Baby hospitalised for suspected bacterial pneumonia.*

Squeezing into our rusty *mutatu* (bus), we handed over the fare to the conductor, who returned to us less than expected change. In response to our indignant questioning, he defiantly stated, "You are *mzungu* (white person) and *mzungu* is money." This was lesson one in a crash course we had inadvertently stumbled into: "Life in Kenya for the naïve tourist." More unsettling than being scammed in day to day life, however, was the rampant corruption in the hospital and university setting.

We completed our placement at Kenyatta National Hospital, the largest referral centre in Kenya, with 1,800 beds, 50 wards and 24 operating theatres. I was based within the paediatric ward and paediatric emergency department.

According to the Corruption Index 2010, Kenya has the dubious honour of being the tenth most corrupt country in the world; [2] we soon witnessed this corruption first hand. Unable to understand Swahili, it took us some time to realise that the patients' relatives waiting in long, reaching lines were actually trying to bribe myself and the other exchange students to see them first, apparently common practice in the hospital. Local medical students at the hospital told us that there were some nursing and medical staff who would provide "better care" and more medication for some under-the-table money. One student told us that he was yet to be allocated a parking permit as he had not bribed hospital administration. In December 2010, shortly before our arrival in Nairobi, the Kenyan government admitted that up to one-third of the national budget is lost to corruption annually. [3]

While it is easy to condemn corruption amongst relatively well-off government officials, it is much harder to begrudge the average Kenyan for participating in this rotting system by applying my moral standards, born high in the comforts of a first-world ivory tower. Doctors included, Kenyan medical staff are paid shockingly low wages in comparison to Australia, despite tougher working conditions including long hours and exposure to an array of infectious tropical diseases, not to mention HIV.

Another eye-opening aspect was the low expectations of healthcare outcomes. While I had expected this to an extent, it is an entirely different experience to witness this in person. In a setting where there is no sphygmomanometer, one cannot expect fastidious hygiene and infection control. Babies shared intravenous fluids, with five infants receiving fluid from the same bag, while children with tuberculosis would be placed next to immunosuppressed leukaemia patients. We saw children with large abdominal masses and heart murmurs who received no further imaging or investigations because they could not afford treatment, regardless of the diagnosis.

Figure 2. *The sink in an isolation room for immunocompromised children.*

On one especially shocking morning we found an intern unsuccessfully attempting to resuscitate a four year-old child. The intern casually stated that he could not find the intubation equipment and thus could only administer oxygen via a bag and mask, while the child's mother was on the floor, sobbing next to her dying son. The consultant walked past the scene, not giving it another glance, and continued on the ward round. Death felt commonplace and omnipresent in every corner of the hospital, like the table in the back of the emergency department where I had directed a mother to change her baby's diaper, until a nurse shooed us away, hissing that it was reserved for the bodies of the deceased children which were sure to pile up by the day's end.

Standards of care and expectations of health are much lower, which is not altogether surprising in a nation in which the average life expectancy is 55. [4] The goal for most is survival, and optimal long term health is a luxury many cannot afford. A clear example of this is the wide usage of chloramphenicol. The drug is cheap and effective, but has with it the fatal side effect of aplastic anaemia. It is for this

reason that oral chloramphenicol is no longer used in the developed world. [5]

Whilst Kenyatta is a public hospital, patients were still charged for medical care. Inevitably, many of the families we saw during our stay were unable to afford treatment. Relatives were forced to leave their children, basically as ransom, whilst they returned to their villages to try and raise money. Sadly, this meant that the now-healthy children would remain at hospital and would thus be exposed to a multitude of pathogens, often falling sick again, and on several tragic occasions, succumbing to these nosocomial infections.

Figure 3. *A ward in the paediatrics department. Single cots were usually shared between patients and their parents.*

I do not mean to imply that our time at Kenyatta was completely disheartening. Doctors there have been known to cover the cost of their patient's treatment themselves. The hospital also helps fund patients whose needs are especially great. I was amazed by some doctors who kept so calm while facing long lines of patients, many of whom were desperately ill. Most inspiring of all were the children themselves, playing in dirty corridors, their faces lighting up when they saw us, calling out, "*mzungu*, *mzungu*!"

I left Kenya angry and frustrated from the corruption I witnessed and experienced on a daily basis, as well as with the abject poverty, which acts both as the cause and effect of the corruption. At the same time, I could not pinpoint the subject of my frustration: the doctors, who were doing the best they could under the circumstances? The entire African continent, grappling with dysfunction on multiple levels? Myself, for being born in a developed country? As I'm sure many of my final year colleagues agree, an elective in Africa is an amazing experience. It was hard to cope, however, with such blatant health disparity and the guilt I felt for being able to fly far away from Africa when my time there was complete. The beautiful children, parents and medical staff that we encountered are as much a part of Africa as its unrelenting problems, which urgently require solutions that I fear will not be in reach anytime soon.

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Conflict of interest

None declared.

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