UROLINK
PROMOTING UROLOGICAL CARE AND EDUCATION WORLDWIDE

TUF Urolink Fellowship Report

Kilimanjaro Christian Medical Centre, Tanzania

12th February – 1st March 2024

Rory Ferguson, ST4

In February 2024 I travelled with Urolink to Kilimanjaro Christian Medical Centre (KCMC) in Moshi, northern Tanzania, to spend three weeks with their urology department. I was supported by a fellowship awarded jointly by Urolink and The Urology Foundation (TUF), with the latter generously providing financial support. I am extremely grateful to TUF and all their fundraisers for enabling this fantastic opportunity.

I first became aware of Urolink through colleagues, with its mission "to promote and encourage the provision of appropriate urological expertise and education worldwide". I first got involved by joining several online teaching sessions, most recently coordinated by Mike Ng and Charlie Stewart, which aim to promote bidirectional learning for trainees in the UK and in Urolink partner hospitals. This was an enjoyable experience, and I was keen to follow it up with in-person visit. (The team are always looking for volunteers to lead and moderate the online sessions so do contact them if you are interested.)

KCMC main entrance

KCMC is a large tertiary hospital with approximately 630 beds, located in Moshi, in the foothills of Mount Kilimanjaro. The urology department, the first in the country, was established over 30 years ago by Lester Eshelman, an American urologist who spent many years working at KCMC. The history of the department and the development of the

THE UROLOGY FOUNDATION

relationship with Urolink is discussed in a podcast with Neville Harrison and Steve Payne, found on the Urolink website. I would definitely recommend listening if you are considering a visit. The department today is very well setup, with its own building on the vast hospital campus. There are two operating theatres, a suite of outpatient clinic rooms including a room for local anaesthetic procedures, a 20+ bed ward, a lecture theatre, a library and offices. The department is one of two centres in Tanzania that offer an approved residency training programme, and I met residents and fellows from across Tanzania, and from Kenya, Rwanda and Uganda. Patients are referred from across Tanzania, making journeys sometimes lasting several days.

Sunset towards Mt. Kilimanjaro from KCMC

On the first day, I got started by joining the morning ward round. Each day (except for Thursdays when there is a quick business round before formal teaching at 8am) there is a teaching ward round lasting about 90 minutes. Medical students (usually third year students on a three-week placement in urology) are expected to have clerked all the patients and be able to present a case each to the resident or consultant leading the round, and then answer follow up questions about management. The effort and time dedicated to teaching was impressive, but the style was a culture shock. It was made very clear quite frequently to the medical students that a greater level of detail and understanding was expected, even at times when I thought they had done well. I could understand the intention to instil the highest standards in the students, but I certainly felt sorry for them at times! The majority of patients were admittedly electively for surgery, although there were a few admitted with typical urological emergencies.

The primary reason for my visit was teaching. I was lucky in that another trainee, Katie Brodie, was visiting at the same time, and so we were able to share the teaching sessions. After the ward round each day, we gave a teaching session to the 24 medical students, usually split into two groups. We covered core topics on their medical school curriculum, including male LUTS,

Shira peak on Mt. Kilimanjaro

incontinence, stones, UTIs, urological cancers and emergencies. The students appeared to be used to didactic-style teaching, so Katie and I did our best to make it as interactive as possible, with case discussions, role-play to practice history taking and viva practice. In particular we tried to encourage them to have a go at answering questions even when they weren't confident of the answer, and to not worry about feeling embarrassed if they were wrong, as the resulting discussion was an educational process in its own right. Several of the students were confident and comfortable at taking part from the start, and it was really satisfying to see others grow in confidence during the visit.

Over the first few days I got to know the medical team. There were four consultants, around 25 residents and fellows, plus five interns. The residents were on a four-year programme, linked to the local medical school/university, which would lead to the award of a Master of Medicine (MMed) in Urology degree and enable them to practice as a consultant in Tanzania. In addition, many of them planned to sit the fellowship exams run by the College of Surgeons of East, Central, and Southern Africa (COSECSA), which would lead to the award of FCS COSECSA, similar to the UK FRCS(Urol) qualification. Although (as I understood it!) not essential for independent practice in Tanzania, the benefit of the FCS COSECSA qualification is that it enables surgeons to practice across the COSECSA countries and is looked upon favourably by hospitals when employing consultants. The fellows were from a variety of backgrounds, with the majority already qualified as consultant general surgeons who had arranged to work at the KCMC urology department for one or two years to enable them to offer urological care in their own hospitals, often in more rural locations across Tanzania and neighbouring countries.

There were five final year residents, with whom we devised a teaching schedule for the residents and fellows. Katie and I ran sessions together each day on a variety of topics relevant

to their future MMEd and FCS exams, in a style similar to our regular registrar deanery teaching sessions back home. We were keen to ensure we delivered high quality sessions so we spent several hours each day preparing for these. The residents and fellows were engaged and enthusiastic, and demonstrated knowledge of international guidelines, even when resource limitations mean routine practice at KCMC is different. For example, the vast majority of patients diagnosed with prostate cancer at KCMC present late with metastatic disease and in those few with possible localised disease, access to MRI is very limited; nonetheless the residents were still keen to discuss the pre-biopsy MRI diagnostic pathway for localised prostate cancer and the evidence base behind it, in case it came up in their exams.

It was great to spend time with the residents both at work and after work, when they took us their favourite local restaurants and karaoke bar! I was interested to learn about their experience of training in Tanzania and their future plans. Three of the final year residents planned to stay at KCMC as consultants, which will no doubt be a fantastic bonus to the department, as the current consultants are spread very thinly across such a busy unit, with clinical, teaching, managerial and research commitments. Each resident had an area of practice that they were keen to develop and had ideas of how to further improve the range and efficiency of services offered by the department. The other two final year residents planned to return to other government hospitals, with plans to bring what they had learnt at KCMC to much smaller and less established units. It was humbling to learn the sacrifices the residents had made through their training. The four-year residency programme is unpaid (apart from overnight oncalls) and a fee is paid each year to be registered with the local medical school/university. Expenses therefore have to be covered by a resident's family or a private benefactor, or in some cases sponsorship by another hospital in exchange for a period of service on completion of training. This puts training as a specialist out of reach of many graduating doctors.

Karaoke night at Amuzz

Aside from teaching, I spent time in theatre and outpatient clinic. In the endoscopic theatre, TURP and TURBT were routine, daily procedures. At present upper tract endoscopy is not possible due to the absence of a C-arm x-ray machine in theatres, but I heard rumours that this is the next target for the department. Thinking of the current drive to reduce carbon emissions in the NHS, a key target of the GIRFT guidelines, I saw plenty of examples of efficiency-driven theatres practices that could (/should!) be copied back home. Reusable theatres gowns and drapes, and large metal drums of sterilised irrigation fluid would hugely reduce the waste generated. In the open theatre, the surgical skills of the residents were very impressive; it was clear they get more open operative experience than trainees in the UK. I observed both paediatric and adult open radical nephrectomies, and several open ureterolithotomy cases, which certainly helped my anatomy understanding.

Tanzanian vs Kenyan leaders of the marathon

Living on the doctors' compound site next to KCMC for three weeks was great fun, and really added to the trip. 'Compound' doesn't really do justice to the lush green area, with the site manager/handyman/fixer of all problems Pauli having created a beautiful tropical garden. There were plenty of international visiting doctors and medical students staying in the cottages dotted around the compound. A busy visitors' Whatsapp group had lots of offers to join weekend trips to safari parks and waterfalls. Joining the swimming pool of the nearby AMEG lodge hotel made the evenings feel like a holiday, after busy days in the hospital. A highlight was the annual Kilimanjaro marathon held one Sunday during my stay, which brought competitors and visitors from across Africa and created a real festival atmosphere.

I feel very privileged to have visited to KCMC and would hugely recommend similar visits with Urolink to other trainees. As Matt Trail reflected in his post-visit report, the visit certainly reminded me of the fortune of training in the UK, and made the usual frustrations and limitations seem trivial in comparison. Indeed, it was inspiring to see the dedication of the staff at KCMC, despite challenges of limited resources. Nonetheless, observing the

THE UROLOGY FOUNDATION

department at KCMC made clear how much has been achieved through the collaboration with Urolink and other partners over the years. In the future, I hope that the department will continue to grow and develop, and be able to offer treatment to many more patients currently struggling to access care, and that the successes of the department can be emulated in hospitals across Tanzania and further afield. This trip has definitely cemented a desire to continue working with Urolink in the future, both in terms of teaching and fundraising, to support this development.

I would like to thank Suzie Venn and Steve Payne of the Urolink committee for encouraging and supporting my trip. It was fantastic to visit at the same time as Suzie and learn from her extensive experience. In addition, I would like to thank Richard Venn and KCMC resident Gideon for looking after me during a bad bout of gastroenteritis, including sourcing IV fluids and antibiotics! Thanks also to all the final year residents, Dennis, Esther, Janeth, Kiattu and Matt, for their warm welcome and hosting throughout the trip. Finally, I would like to thank TUF for their generous support in making the trip possible.