ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1. Compare the pattern of disease/illness seen at Rushere community hospital and the surrounding villages, with larger cities of Uganda (e.g. Kampala): a comparison of rural vs urban Uganda.

The majority of diseases presenting to Rushere Community Hospital are largely of a communicable nature. Notably one of the most common is malaria, and quinine therapy often administered in the case of fever before a diagnosis is formally made. Furthermore blood films are considered unreliable, and quinine therapy often therefore administered even if the test is negative. Although patients will often present quite late, often due to difficulties travelling to the hospital or sometimes a lack of money, mortality from malaria is low because therapy is so promptly commenced. It is also possible to buy quinine over the counter, and patients far from hospital will often therefore self-medicate should they become unwell.

HIV continues to be a major burden in Uganda. Currently it is said 7.2% of people in Uganda are living with HIV, although it is thought the number may be higher. HIV testing is however free, and anti-retroviral therapy also free throughout Uganda. All patients are usually tested on admission, or on arrival to any clinic. Unfortunately one of the biggest complications is the stigma attached to HIV, and patients are therefore reluctant to take the medications for fear of people knowing of their condition. As a result, it is not uncommon for patients to present to hospital very sick, cachectic with CD4+ counts of less than 10. On the other hand, access to free anti-retroviral therapy has drastically improved the management of HIV and those taking them are very well. I was very pleased to see lots of advertising campaigns throughout Uganda promoting the use of barrier contraception, and free condoms available in the outpatient department at Uganda.

Whilst we were at Rushere, a general physician from the nearest regional referral hospital in Mbarara had set-up a twice weekly clinic for patients with chronic diseases. This would bring in lots of patients with uncontrolled diabetes, hypertension and various other illnesses. These are all, however, much less commonly seen than they are here in the UK. From my experience at the hospital, atopic conditions are also rare.

2. How do the resources available to health practitioners at Rushere Community Hospital compare with those seen in NHS hospitals?

Health care facilities in Uganda are either private or government-run and therefore subsidised. Private hospitals would often have the same resources, but were less crowded. Attendants were still utilised, however, whereby a family member/ friend would be in charge of all of a patients basic needs, including providing food, water, washing clothes, toiletting, etc. This in itself is very different to the UK, where such things are usually provided by nurses or domestic staff. Patients were sometimes forced to attend private hospitals if they were nearest or referred by health centres, e.g. for emergency caesarians, and were unable to pay for their care. Whilst in Rushere I heard several stories of women 'escaping' at night, running away to avoid their fee.

There were several other differences noted between healthcare provision in the UK and in Uganda. To begin with, there were no oxygen saturation probes, and oxygen saturations therefore unrecorded. This was also true of the operating theatre, which lacked both saturation probes and any other monitoring devices other than a blood pressure cuff. Patients were anaesthetised despite this. In addition the hospital had no oxygen in the hospital and those requiring oxygen therapy were referred to Mbarara Regional Referral Hospital, which often meant incurring a 150,000 ugandan shilling fee for ambulance transport, approximately £33.50. Such a fee is often very difficult for families to acquire, and the patients would therefore be forced to remain without oxygen at Rushere.

Similarly to the UK vaccination in Uganda is free, and a vaccination programme of tetanus, diphtheria, polio, pneumococcus, measles and BCG is in place. Rushere provided two outreach clinics a week to schools and villages to offer not only vaccination, but also free mebendazole for de-worming, and vitamin A to children and adults.

For me, one of the most saddening things to see was how much of an impact money made at Rushere. In the UK we are fortunate to have the NHS and therefore free medical services, but I found the idea of patients having to 'escape' from Rushere because they were unable to afford to pay for the emergency caesarian they required to deliver their baby, very sad. One patient was now working at the guesthouse because her husband had left her at the hospital in labour with no money, and never came back. Such situations were unfortunately not uncommon. The hospital did however have a theatre, a paediatric department, general ward and a private ward, and had lots of medications and equipment to provide health care for the majority of patients admitted to the hospital. For scans and the majority of surgical procedures, however, patients would have to travel to Mbarara.

3. What are the most prevalent maternal complications seen at Rushere Community Hospital? Are these also the most prevalent complications identified in the UK?

The most prevalent maternal complication seen at Rushere is obstructed labour, which accounted for the majority of indications for caesarian. Patients would then be admitted for 5 days post-caesarian for monitoring and antibiotics. Post-discharge, patients would receive another 5 days of oral antibiotics. Despite this, wound infections were also relatively common, as was neonatal sepsis. Such complications are less prevalent in the UK for a number of reasons. Firstly, women are screened for vaginal carriage of group-B streptococcus, one of the pathogens most commonly associated with neonatal sepsis. If the women screens positive, then they are treated with antibiotics to prevent neonatal sickness. Women will also receive antibiotics post-caesarian in the UK, similarly to women in Uganda, however facilities in the UK are arguably cleaner and sterile dressings more readily available should they need to be changed. Therefore surgical sites of women in the UK may become infected, but it is much less common.

Due to resource limitation, the threshold for caesarian in Uganda is higher. Women therefore often deliver breeched babies vaginally. As a result, cervical tears and perineal trauma is more commong in Uganda. Unfortunately I witnessed the delivery of a dead baby, where caesarian for prolonged labour had been delayed. Should resources have been more readily available and funding less of an issue, the baby could have been delivered earlier, which may have altered the outcome.

Another reason for the difference may be due to the early discharge of women from hospitals in the UK, reducing the risk of hospital acquired infections. Furthermore, women in the UK are followed up in the community to make sure both mother and baby are ok. Any problems are therefore more likely to be identified and managed, whereas women in Uganda will next be seen when their child is vaccinated and 2-3 months. On the other hand, retained products of conception is more common in developed areas than developing countries.

4. How will the experience of working in hospital in a third world country, with limited resources and language barriers, affect my future practice?

My experience at Rushere Community Hospital has been invaluable to my future career. I chose to undertake my elective in a developing country in order to have a more hands on experience and improve my practical skills. In many ways observing doctors, medical students and other healthcare providers in Uganda, was enlightening and helped me to understand the importance of being flexible and making use of what you have.

I think it has helped build my confidence for my future career as a doctor, and improved my ability to work as a team. The experience of being a medical student in Uganda is much more hands on, and a lot could be learnt from students there and I have learnt the importance of asking for help where you are otherwise unsure, and the importance of utilising all members of the team. Furthermore it has highlighted the importance of not taking things for granted, and therefore the importance of ordering tests only after careful consideration of what the benefit of their result will be in managing your patient.

Most importantly I learnt a lot during my time at Rushere, and it has really helped to prepare me for becoming a doctor. I have also made some great friends and developed a desire to return to Africa to practice medicine in the future.