ELECTIVE (SSC5b) REPORT (1200 words)

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

There is a stark difference in the level of care in Malawi compared to the UK and unfortunately this is reflected in the under 5 mortality rates of 4.9 per 1000 birth in the UK compared to 112 per 1000 in Malawi.

Provision of paedIatric care is by public hospitals as well as privately funded clinics run as charities. For wealthier families there are also private hospitals but many wealthier people travel to South Africa for major operation etc.

As mentioned above there is a much higher level of under 5 mortality in Malawi. Additionally there is a much higher live birth infant mortality of 66 per live births in Malawi compared to 5 Per 1000 live births in the UK. (2012 figures from WHO) Notably in Malawi there is a steady improvement and this number has decreased from 72 per 1000 in 2008. However, this stark figures reflect the basic health care available, as well as different health practices and beliefs. In Malawi the major causes of infant death are pneumonia (23%), underweight (22%), diarrhoeal diseases (18%) and malaria (15%). In the UK, cancer is the commonest cause of death, followed by congenital abnormalities and then respiratory infections.

Malawi is one of the poorest countries in the world with a GPD per capita of $300 compared to $40,000 in the UK. Both countries have a public health service free at the point of service. However, in Malawi, often the cost of travel to the hospital and the disruption to employment can inhibit patients and their parents from accessing the limited services available. Additionally parents may attend the local traditional healer as opposed to the western hospital.

The Queen Elizabeth hospital, Blantyre is the largest hospital in Malawi and has 10 different specialised peadiatric wards, as well as a paeds A& E. It is a tertiary referral centre for Malawi and is the only hosital in the country with MRI imaging. (Although it does not have a CT). After 10 years of campaigning and raising private funding, there are 2 newly-opened specialised paediatric theatres and wards. Additionally there are 6 paediatric intensive care beds available- 2 are available for surgical cases, 2 for medical cases and 2 for research. The beds are only available if the child has no underlying medical conditions (e.g. HIV, congential abnormality) and was previously healthy before admission. Therefore many patients do not qualify for the beds. However, this is still an exciting development within paediatrics in Malawi and will hopefully improve the stark figures.

There are chronic diseases such as asthma and epilepsy, as well as high rates of malaria, malnutrition and complications of untreated HIV and TB. Additionally, in Malawi there are children living with complications of diseases easily treatable in the UK. For example, I saw one patient who had had a klebsiella pneumonia that had spread to a brain causing hydrocephalus. The child therefore required a ventricular-peritoneal shunt. this unfortunately got blocked and the neuro-surgeons were not available to fix it.

The placement enabled me to develop my paediatric skills. I saw many presentations at the later stage than in the UK e.g. presentations of malaria (with complications of enlarged spleens and livers) and

pneumonias (with positive clinical signs) it was an excellent opportunity to hone my cardio- respiratory and abdominal examinations. Additionally, as there were many neurological cases, I developed my neuro examination skills. For example, I assessed for high intra-cranial pressure (by examining for a bulging anterior fontanelle and 'sundowner' eyes) as well as learning the adapted paediatric Blantyre coma scale.