ELECTIVE (SSC5a) REPORT (1200 words)

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

- Describe the pattern of infectious disease in the communities of rural Malawi. Discuss these within the context of worldwide prevalence and how they differ from the UK.

My placement at the world medical fund involved outreach to rural villages in southern Malawi. In my three weeks of placement I visited nine villages. This helped me to get a broad view of the medical problems which affected those children living in rural villages. The problems I saw most commonly were malaria, worms, respiratory tract infections, tinea capitas, scabies and impetigo. Malaria in particular affected about half of the children at each clinic, sometimes very severely- causing convulsions and reduced consciousness. The experience showed me the diseases affecting children in villages of Malawi were quite different to those affecting the children at my previous placements at general practices in the UK. Also children with more severe illness were more common, which in the UK would usually have presented at hospital. In the UK in primary care I most commonly would have seen ear infections, respiratory tract infections and a variety of dermatological conditions. The conditions in rural villages were also different to those I saw on a day visit to the local hospital in southern Malawi, which seemed to reflect the difference in wealth. In poorer areas disease like scabies and worms were noticeably more prevalent, though incidence of malaria seemed to remain much the same.

- Describe the provision of primary care to communities within rural Malawi and the contrast to care in the UK.

In rural Malawi the provision of primary care is largely by outreach clinics like ours. Some of the villages are very isolated, and would take us hours to drive to. The people within these villages could not easily get to and from walk in services at local hospitals. For this reason the outreach clinics were formed. We went to each village once a month. Though this did provide some primary care it also was clear that some children were waiting many days whilst unwell for the clinic to visit, so the system was far from ideal. There was also the issue of people using witch doctors, sometimes for many months, before seeking more conventional medical care. In some traditional communities this was the first port of call for primary care of medical complaints. In comparison to the UK, which has many general practices as well as walk in services, the primary care was much more limited. In places in Malawi which were less rural, there were walk in services provided by local hospitals. These were widely used by the community.

- **Describe the public health strategies to reduce the incidence of infection in rural Malawi and compare this to the UK.**

During this placement we saw the more rural side of Malawi, which can be harder to reach with public health campaigns. The most effective strategy I noticed was that of the charity when we went to each village, and was mainly to provide education. The villagers were taught songs about health which they would sing at each clinic. These talked about having children at wider intervals, family planning and other relevant issues. The village also received teaching from a Malawian nurse heavily involved in the charity. She would talk to the villagers about symptoms of infectious diseases and what to look out for, for many different conditions including malaria and HIV. She would educate about how to prevent them and when to seek help. Also she talked about the importance of

treatment and adherence to treatment. These were very interactive sessions and it seemed like a very effective way to reach people in villages who may otherwise not receive much public health education. This however only involved the women and children of each village, as many men would be out farming or working elsewhere at the times the clinic visited. Widespread testing for disease was also implemented by the charity, many children were tested for malaria. This was however only provided if some symptoms were evident and was not a screening programme, as funding was not provided for screening. Other public health strategies such as malaria nets were not evident in the villages we visited. Some had nets, which were instead being used for vegetable patches, fishing nets or other practical endeavours. The strategies in Malawi were vastly different to those in the UK, largely due to the very different range of disease.

- To develop as an independent and competent clinician, whilst utilising limited resources.

This placement involved mainly independent practice, whilst also allowing the support of a wider team to look to for advice. At the beginning it felt slightly overwhelming, to be doing consultations in an unfamiliar language and with patients who had conditions I had rarely seen in the UK. But I soon realised the support of clinical officers and my fellow students meant if I ever felt unsure I could look to others for advice. It helped me to make diagnostic decisions similar and to those I will have to make as a foundation year doctor; which investigations will be helpful, what my differentials included and also how best to treat the patient when a diagnosis was made. There were many limitations when we were on outreach to both investigations and treatment. The only investigation available to us was a rapid diagnosis malaria test. Otherwise we had to use clinical judgement to make a diagnosis or make the decision to recommend the child attend the nearest hospital for further investigations. This however was not always a possibility for those in the village- some could not afford the journey. This meant a lot more reliance on clinical examination and history than may be necessary in the UK. I think though that was daunting at first it did mean my clinical assessment improved and I found I trusted my own judgement more as the placement went on. The treatments we had available were also limited, and we sometimes ran out of medications during clinics, which frequently included over 300 children each day. This meant we had to be more aware of alternatives and take the initiative to research the options available to us. This helped to grow my independence and become a more creative practitioner.
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