ELECTIVE (SSC5a) REPORT (1200 words)

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

1. What are the common presentations in a community health clinic in the Amazon rainforest? How does this differ from the UK?

During my elective placement I worked in two environments. During the first week I was worked with Sumak Kawsay Wasi, which translates to "Wellbeing House" in Kichwa, the local indigenous language. This organization typically works with the poorer indigenous communities in the Tena province and beyond. During my week with them I was part of a "medical brigade" – this where a charity, this time a North American one called MedLife, come to Sumak Kawsay Wasi and provide support and resources to hold outreach clinics in harder to reach communities on the outskirts of Tena where residents may otherwise not be able to access healthcare. As part of this, they bring together local doctors, dentists, nutritionists, psychologists and other healthcare professionals to staff these clinics, with the organization provides equipment and a limited (but pretty good) pharmacy. In my second and third weeks I was based at Centro de Salud Urbano Tena, essentially a primary care practice in town.

During the medical brigades we mostly saw children, young women and older persons, assuming because it was during the working day. The overwhelming presentations in children was of parasitic stomach infections and malnutrition. This is due to the lack of clean water resources available to this population group. You can't drink the tap water in this part of Ecuador. Most Amazonian Kichwa families will instead use water from the river for everything, which over the years has become more and more contaminated. We are very fortunate in the UK to not have this problem. I've never felt so grateful to be able to drink tap water!

Probably the most common causes of presentations overall, and a problem I was surprised to find, was that of teenage pregnancy and subsequent neglect and poor care of the children. Whilst contraception is theoretically free in Ecuador the public health system is widely lacking in pharmaceutical resources and as a result it has not been available in this region for some time. Sex education is also woefully lacking, abortion is largely illegal, and so it is not uncommon for girls are young as 13 to become pregnant and bear children. These girls themselves are living in poverty, have not attended a good-quality school and may have been treated badly. Their children experience the same, and the poverty cycle continues. Whilst at the brigades I mainly saw the affect on the children – 5 year-olds with the height and weight of 3 year-olds, very poor dentition, general malnutrition – but whilst in the primary centre I saw more of the pregnant girls and the lack of contraception. I also saw a couple of cases of suspected child sexual abuse, which my GP (or "medical general" as they are called in Ecuador) said was unfortunately not uncommon as a presentation amongst these indigenous communities. Often committed by family members or other close members of the community but gone unchecked by parents who are too busy working to be able to properly care for their children. This was upsetting to see and not something I have experienced during placements in the UK (although of course it happens here too). I also saw many cases of HIV and TB than I would have expected to see in this number of patients in the UK.

Being in the Amazon, I expected to see lots of strange tropical diseases, but I saw next to none of this. I'm not sure whether it's because they are more likely to present to A&E, or that we were not deep enough into the Amazon for them to be widely prevalent here.

I was told by my GP that diseases of modern society such as diabetes, heart disease and hypertension are widespread in Ecuador, however I saw very little of this in my time there.

2. How is healthcare organised and delivered in this remote area of Ecuador? How does this differ from the UK?

I was pleasantly surprised to find that Ecuador has a universal public health system funded by the government. Anyone, regardless of income, can visit and receive treatment at primary care centres and hospitals for free. Ecuador follows a similar primary and secondary care system to the UK regarding referrals. Unfortunately, this system is under enormous strain and is lacking in resources. There is a free pharmacy at the primary care centre but they were out of all common medicines and major antibiotics during my 2 weeks with them. Doctors instead have to

write prescriptions that patients have to take out from private pharmacies. To me, the medicine at least felt cheap - $1 for a 3-day course of antibiotics – but to the many people living in poverty, this cost may be impossible. Several patients came in needing sutures which a family member first had to go and purchase from a private pharmacy as there was none at the health centre. A friend who had to attend A&E for stitches reported a similar situation.

Remote and rural areas are commonly staffed by newly qualified doctors, who have to complete a year of working in these environments as a mandatory part of their training. And of course, the medical charities who come to support the outreach clinics are a key part of delivering healthcare in these environments.

3. What is the cultural attitude towards healthcare in this part of Ecuador? How do modern medicine and traditional Amazonian medicine intersect?

Shamanism and the use of natural Amazonian medicine is widespread in this part of Ecuador. During my stay I had the opportunity to meet several shamans and received guided tours of their medicinal forests. I even attended a ceremony where a shaman took ayahuasca and performed a “limpia” (a cleansing) on my, to clear the “bad energy”. Bad energies are widely believed to be a cause of many medical ailments and the advice of shamans is often sought out as the first resort. However, the two do coexist, and some shamans may advise a visit to a doctor or health centre in some cases. When I became unwell during my last week on placement, my host family initially performed a limpia on me before then taking me to the health centre to see a ‘western’ doctor. I think shamanism etc would only be of benefit if you were already bought into that belief system already. As a sceptical foreigner, this therefore didn’t really work for me. However, I was very impressed with the vast amounts of knowledge of the medicinal properties of the plants that the local families held.

4. To develop my Spanish language skills further, both through homestay immersion and also specifically within a medical context. To determine whether working in Spanish in the future would be a) something I would like to do and b) be realistic to aim towards.

I spent day-in day-out speaking Spanish for three weeks with occasional breaks for calling home and spending time with other foreigners in the town. It was a fantastic workout for my Spanish and I think my general conversation skills developed considerably, as well as developing my medical vocabulary and how to converse with patients and colleagues in the medical context. I am still not at a level where I would feel comfortable to see patients alone but believe that this is something I could achieve with more time if I wanted to, which is exciting. I’d like to get involved in Latin American healthcare projects in the future and believe I could have a lot to offer as an almost-bilingual doctor.