ELECTIVE (SSC5a) REPORT (1200 words)

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

To learn more about the pattern of disease in Uganda and be able to compare it to that in the UK.

During my placement I have gained experience of a wide range of conditions. Some of these are common in the UK such as diabetes, pre-eclampsia and pneumonia. Others I came across for the first time such as typhoid, malaria, uterine rupture.

A major difference between the conditions seen both countries is the prevalence of tropical, infectious diseases. These are rarely seen in the UK but are endemic to Uganda and so the way that people respond to them is quite different.

Generally, it seems that people in Uganda often present to healthcare services at a later stage than their counterparts in the UK. This could be due, in part to the accessibility and availability of medical care, as well as the cost. Seeking medical help in Uganda could mean a trip taking a whole day and potentially involving a significant financial burden. These factors may prevent a person's prompt response to symptoms and in some cases encourage them to look for closer, more economical alternatives.

Conditions such as diabetes and hypertension are treated in a similar way in both countries. Once a diagnosis has been made, people come for regular reviews to have their medical parameters, such as blood pressure and blood sugar, levels, measured. They are treated accordingly with lifestyle advice or medication.

There is similar prevalence of hypertension in the two countries however diagnosis and treatment is significantly lower in Uganda with higher rates of untreated stage 2 hypertension (1). This is also the case with other so-called 'lifestyle diseases' such as obesity and associated metabolic conditions. In the UK the incidence of diabetes is almost ten times that of Uganda, but the number of people with undiagnosed hypertension in Uganda is around twice that of the UK (1).

1: https://ncdrisc.org/data-visualisations.html

To learn more about the structure of the healthcare system and how this compares to that in the UK.

The health care system in Uganda is largely decentralized with local clinics providing a large proportion of the care. This is managed by local government, supervised by a central government ministry. At the national level in Uganda, the Ministry of Health is responsible for developing policies, monitoring standards and coordinating response to public health emergencies. The Ugandan government finances the health sector through both the central government and local government budgets. The central budget provides funding for national-level health programs such as disease control. The local budget provides funding for district-level health programs and services. Uganda also receives significant contributions to healthcare in the form of aid from international charities.

The NHS, still runs as a largely centralized organization, managed by the Department of Health and Social Care, which is responsible for setting policy and providing funding from general taxation.

In Uganda there are different levels of health centres from I-IV depending on the range of services they offer. A centre more advanced than a health centre IV is then graded as a hospital. There are district, general and regional hospitals which follow a similar system to the UK. Kasangati health centre is a level 4 health centre which means it is one denomination before being graded as a hospital.

A clear difference between the local response to health and disease between the two countries is the economic disparity and the challenges this poses to the ability to provide health provisions and respond to the populations health needs due to less infrastructure, availability of medication and equipment, wages for adequate staffing etc.

In both countries there are also privately-funded options for healthcare. In Uganda this is divided into private-not for profit and private for-profit organisations. Treatment can be paid for either by using health insurance or simply on attendance as in the UK. In Uganda private provision is generally beyond the budget of the average citizen.

In theory, the government funded facilities should be free and accessible to all. However, there are often shortfalls of resources and basic medical products can become scarce and so patients have to provide certain items for

themselves. This might include sutures, cotton wool, sterile gloves and medications. Another consequence of this is that sometimes services can't run at all. For example during my time in Kasangati, the family planning clinic was unable to operate due to a lack of most contraceptive supplies.

To get a better understanding of some of the social, political and cultural factors that affect healthcare in Uganda with some comparison to those that affect healthcare in he UK.

Some of the differences between health care in Uganda and the UK are due to cultural and sociopolitical factors. At Kasangati Health Centre IV, the provision is largely directed to the care of pregnant women or mothers and their young children. The antenatal and maternity wards were the busiest wards at the health centre and a significant proportion of the surgery carried out in a week seem to be Caesarean sections. This also seems to be mirrored in the structure and focus of the medical training with obstetrics and pediatrics being core specialties throughout medical school and internship. This is a reflection of need with the birth rate in Uganda being more than three times that of the UK and almost half the population being 14 years or under (2).

This discrepancy in birth rates is due to a number of factors including higher infant mortality in Uganda as well as cultural differences surrounding family planning and contraception and the fact that abortion is, for the most part, illegal. Contraception is legal in Uganda however it is not as commonly used as it is in the UK and family planning can be a controversial topic. It is something I discussed with various healthcare professionals during my placement. In general, it seemed that there was also a different attitude towards sex and relationships in Uganda, with a relatively high proportion of single mothers as well as teenage pregnancies. This was something that increased 'exponentially' during COVID-19 pandemic and Uganda currently has the highest teenage pregnancy rate in East Africa (3). In the UK, there are several benefits available to lone parents as well as many support services offered by various third-sector charity organizations offering free services. Although the financial support that people in the UK receive does not reach all of those who need it and is often not sufficient enough to cover their needs it seems to have a wider reach than equivalent government-led social support in Uganda. A UNICEF report from 2021/2022 stated that ' There are also support provisions In Uganda, however, 'Social protection remained persistently underfunded, with less than 3% of Ugandans covered by at least one social protection benefit prior to the COVID-19 pandemic – well below the African average of 17.8%' (4).

2: https://www.statista.com/statistics/447698/age-structure-in-uganda/#:~:text=This%20statistic%20shows%20the%20age,65%20years%20old%20and%20older

3: https://www.unicef.org/uganda/media/13666/file/National%20Strategy%20to%20end%20Child%20marriage%20and%20Teenage%20Pregnancy%202022-2027.pdf

4: https://www.unicef.org/reports/country-regional-divisional-annual-reports-2022/Uganda

To develop my confidence in practical skills and clinical decision making.

During my time in this placement I have developed my confidence in a number of ways and my skills in a number of areas - personal and professional. Travelling to a new country on my own was an experience.

There were several pre-interns who were waiting to start their internship which is equivalent to FY1/2 in the UK. After talking to them about our different medical school experiences it became clear that the training a student receives in medical school in the UK is quite different from that which a medical student in Uganda receives. They are taught more advanced practical skills from their first clinical year and they taught and mentored in a more hands-on way from earlier in their training. So, despite being at a similar stage in our training, their clinical skills were much more developed than mine.

This genuine interest in teaching that everyone at the clinic seemed to have and of 'learning by doing' meant that they were keen to get me involved. This meant that I had the opportunity to practise many different clinical skills. Some of these I had previously used in the UK, such as examining pregnant abdomens and vaginal examinations. Some were completely new to me such as assisting in Cesarean sections and delivering babies.

There were many situations where healthcare professionals at the clinic would sit and go through cases with me.

These case-based discussions allowed me to develop my clinical-decision making skills by allowing me to think through what I would do in similar situations. I learned a lot by having someone discuss my suggestions and pointing out those that would work and those that would need further investigation or be managed in a different way.
As I only had 4 weeks at the clinic, I had to get used to new surroundings, while learning a new language and settle into a new healthcare setting at the same time. I was very pleased with my ability to adjust quickly. I was particularly pleased that I was able to build professional relationships with staff at the clinic in the short time I was there. This has been an extremely valuable experience for me.