ELECTIVE (SSC5c) REPORT (1200 words)

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

1 Describe the pattern of diarrhoeal disease and TB in the Philippines compared to the UK

In my limited experience, the burden of diarrhoeal disease seemed less than expected. Perhaps this is limited by the widespread availability of purified drinking water, or the tendency of poorer people mostly affected to cope at home without seeking medical help in the first few days, with subsequent more serious cases going straight to hospital.. However dysentery-causing agents are more prevalent than in the UK and perhaps this is reflected in the mortality from diarrhoeal disease of 8/100,000, compared to 1.9/100,000 in the UK. (http://www.worldlifeexpectancy.com/cause-of-death/diarrhoeal-diseases/by-country/)

The difference in TB incidence is more stark, with 292/100,000 cases in the Philippines as opposed to 13/100,000 in the UK. (data.worldbank.org/indicator/SH.TBS.INCD/countries) However as is well known, East London sees the highest incidence of TB in the UK and in the borough of Tower Hamlets, this is comparable to the national incidence in the Philippines. The widespread availability of directly observed treatment, short-course (DOTS) centres also highlights the burden that tuberculosis poses on the general population, and the efforts to address this.

2 Describe the provision of primary care and referral to secondary care +/- private secondary care in the Philippines in contrast to the UK

Primary care in the Philippines is provided by various institutions, ranging from government-run, semi-private and private. Health promotion and education is often carried out by barangay health offices that have extensive knowledge of local at-risk families. They often stock a limited supply of medications that can be dispensed by visiting doctors on field/outreach days. However, these are at the mercy of local authority funding decisions that can be inconsistent and easily influenced in some cases. The emphasis locally was being placed on addressing hypertension, diabetes, tuberculosis and malnutrition. Medical interns at CIM rotated through being on duty in the health centre, carrying out mess duties and field days which consisted of visiting their respective zones, armed with local knowledge provided by community leaders and targeting at risk families for close monitoring. It seems that there is a very large drive to bring preventative health care out into communities. Government doctors will often combine health drives such as “Operation Tulig” (mass circumcisions held in schools/community centres etc.) with mobile health clinics carrying out consultations. It is interesting to see so many resources put into a practice this is seen as unnecessary in the UK, however it holds an extremely important place in Philippine culture. Patients can be referred to secondary or tertiary centres which are similarly split into government, semi-private and private services, often provided all on the one site. Personal finance and membership of health insurance programs will dictate which facility you can afford, and this will in turn be reflected by the number of people you share your bed with and whether you are treated by interns, postgraduate interns, residents or consultants to a certain

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extent. Philhealth is the largest national insurance provider and membership of it is strongly encouraged. The income of families is always explored during consultations and this revealed to me how unlikely such memberships are for many families. Contrast this with the free access provided by the NHS and the unrealistic expectations of some UK patients becomes all the more frustrating.

3 Describe the treatment and prevention of TB in a different country and explore the causes of diarrhoeal disease in a SE asian climate

The treatment regime of TB echoes that of the UK with quadruple agent treatment for 2 months , followed by 4 months of dual treatment in simple cases. This becomes more complicated with relapse cases, patients lost to follow-up and drug resistance. There is a very large emphasis placed on directly observed treatment, short-course (DOTS). This aims to achieve a standard approach and effective strategy of detection, treatment and monitoring that will reduce rates of relapse and drug resistance. However with the concentration of people living in small areas, it seems almost inevitable that cases would spread, not dissimilar to parts of East London. While the number of tests available in small health centre laboratories is limited, the ability to carry out sputum smears appears to take priority, facilitating the early identification and rapid commencement of treatment.

With respect to diarrhoeal disease, the majority of cases are caused by enteric bacteria, viruses and amoebiasis, however this complaint made up less of the caseload than I expected. Whether this is due to the ability of people to cope at home or not, I'm not sure. The standard drinking water source for most people is filtered, purified water, however sanitation levels in certain barangay(town zones) definitely lend themselves to faecal -oral contamination. Similar to the case of sputum smears, faecal testing is available on-site, with a much quicker turnaround than you would find in a UK hospital. This can potentially identify a causative agent upon first presentation to health services and quickly guide antimicrobial therapy if it is indicated.

4 Explore my ability to work in a supply and service limited environment, in unfamiliar surroundings

The change in environment is certainly something that takes time to adjust to, however, once you get past that, you realise that the basic medicine that is being performed is similar to that in the UK, with the same principles and aims. The first striking difference is the lack of clutter and equipment that you would find in a UK GP's office. Rotating interns (i.e. equivalent to 4th/5th year UK students), who do the vast majority of clerking, generally provide their own equipment, including manual sphygmomanometers, pulse oximetry metres and ophthalmoscopes. Other materials, such as dressings, sterilising agents etc. can be charged for and are in limited supply, so it's very important to plan out exactly what you will be doing to avoid excessive waste and cost to the patient. There were very few emergencies while I was on site, however, should they arise, there are similar limitations to interventions, with no defibrillator available and limited airway management devices. Given that such emergencies would be handled by the equivalent of a medical student and FY1, it made me question whether I could adequately handle such a situation and highlighted the amount of support and protection that we have as students in the UK. Although supplies are limited in this facility, patients do have access to a wide range of tertiary services, albeit at a price. A discussion with one woman about her husbands ERCP and subsequent laparoscopic cholecystectomy, seemed in stark contrast to their living environment of a rented single room constructed of corrugated iron and recycled wood panels. I think more than anything, this difference in available resources affected my level of comfort more so

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than my ability to perform basic patient assessment, albeit with some borrowed equipment. Possibly the largest difference I noticed is in the organisation of responsibilities among medical staff and patient-ownership that, after 5 weeks, is still a mystery to me particularly in secondary care.

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