ELECTIVE (SSC5b) REPORT (1200 words)

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

Church of Uganda Kisiizi Hospital is a rural community hospital serving the southern most part of Uganda bordering Rwanda. The hospital itself is powered by the nearby Kisiizi waterfall allowing for far more reliable hydroelectric power than most of Uganda endures. The hospital is partly funded by the Church of Uganda, this is an interesting point, treatment available here is much discounted compared to the cost in the government hospitals. The facilities and staffing here are also superior to the government hospitals.
on the second floor of the building. The major illnesses presenting at the hospital are malnutrition, vomiting and diarrhoeal illnesses and malaria.

Paediatrics in Kisiizi Hospital is run as a paediatric ward with each bay denoting different levels of care, a room used as the high dependency unit, 2 isolation rooms and then the special care baby unit is off the end of the maternity ward.

Malaria is prevalent in this region of Uganda, only *Plasmodium falciparum* has been isolated at Kisiizi. Malaria is not something I have come across in the UK, although it is a differential diagnosis for an acute illness in a recent travelled patient. The main symptoms of intense headache and fever are reasonably non-specific so I wonder how easily I would think of malaria in the UK when presented with these symptoms. The treatment here is 3 doses of Artensuate followed by 3 days of Coartem (Artemether/Lumefantrine). It is easy to treat with early presentation and that is one of the major struggles in an income poor country. Seeking medical help is expensive, not only directly for the treatment, but the majority of Ugandans particularly in this area are rural mountain people. Having a child in hospital means the mother or main carer is away from the home all day as day to day care of the child including washing and feeding is provided by the family of the patient. If the infant is still breastfeeding then the mother will have to stay with the child, sometimes the entire family must also camp out at the hospital. The cost of transport to the hospital is also a major factor in presentation at hospital. There are many complications to malaria, but one of the most serious is development of cerebral malaria. This carries a very high mortality rate and is a massive concern for late presentation of malaria patients.

Malnutrition is a big reason for admission here in Kisiizi. Most families in this region are below the poverty line, there is lack of education and availability of family planning and families tend to have more children than they can necessarily afford. With limited food and nutrients babies are often are exclusively breast fed for as long as possible. This leads to high rates of malnutrition, these are classified in Uganda as malnutrition with or without oedema (replacing Kwashikwor and Marasmus). The severity is calculated using markers such as dehydration and malnutrition is diagnosed using a mid upper arm circumference (MUAC). The child is treated on one of three treatment pathways depending on whether they are mild, moderate or severely malnourished. Treatment in these patients is a slow and delicate process. Their small and weak bodies are immunocompromised and cannot cope with large volumes of liquid or solids. The treatment is often painstakingly slow and complicated by opportunistic infections and other health problems. The nutrition bay at Kisiizi is at one of ward, on the opposite side to the diarrhoea bay with the hope of protecting these patients from contracting diarrhoeal illness further complicating their recovery and care. Malnutrition was a very interesting point for me to see as it is not common in the UK and there are several clinical signs associated with it that I have not seen before.

Another interesting case I witnessed was of a 1 year old girl who presented with diarrhoea, severe malnutrition with oedema and was HIV positive. The mother had 2 other children and there were at least 2 fathers, both of whom were not around. The mother was visibly not coping, when entering the isolation room there was a strong smell indicating that the child was not being cared for properly. The child's clothes were filthy and the child was desperately unwell. We cared for the infant for 3 days with fluid replacement and high energy milk. They had wide spread skin breakdown due to the oedema which resulted in sores all over their body. We found some new clean clothes and advised the mother on washing and hygiene techniques to care for her child. Unfortunately this was a very severe case who presented at such a late stage that after three days of care the infant passed away.

It was clear to me throughout this care that the mother was not coping. She was not caring for the child properly and more than once the nursing staff would essentially tell her off and she would be reduced to tears. Her other children were demanding of her time and the middle child would need constant breastfeeding when we were present in the room to settle him. All the children and the mother were unkempt and in filthy clothes. This was a very poor family with no support. There were no other family members around to help. The mother was not able to collect her antiretroviral medications for her HIV infection as she could not afford the transport to the clinic. The whole family was malnourished and the mother had waited a long time to seek medical help due to the cost of the treatment. This was perhaps one of the cases that stood out for me as a strong comparison to the English healthcare system. This wasn't just a case of medical treatments available and complex tests, but more this was a case of social and psychological support. The NHS has many faults, but in this case I was reminded of how much more the NHS offers patients other than just clinical medicine. In the UK this mother would have been helped and intervention would hopefully have been made at a much earlier stage. She was not coping, she needed help, she needed support, both financially and socially. These things were not available here in Uganda, but are available in the UK. The child who passed away needed support. She needed intervention at a much earlier point. She needed her mother to care for her properly and to me that was the startling difference between Uganda and the UK in this case. Support for the mother could have perhaps made a difference in this child's life.

Of course that is not a definite. The child and mother may have slipped through the cracks; they may not have attended their GP or picked up ART in the UK. The mother's mental state may not have been noticed. On a side note treatment for depression is not common in Uganda. But I would like to think there would have been more opportunities for this family to have received some help. And in the UK help is available and to me that was the saddest point in this case, surprisingly not a fancy diagnostic tool or a treatment not available in Kisiizi, but social care and support for a family as well as better infrastructure to mean ART medication is more widely available. Whether social care on the NHS will be available in a decade is a worrying point and unfortunately that seems like more of a political question than a health care one.