ELECTIVE (SSC5b) 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 prevalent medical conditions in rural Malawi and how do they differ to areas of rural UK?

There were a large number of similarities and differences between prevelent medical conditions in Malawi and The UK. As the clinic acted as a local source of primary care, similar conditions included many general paediatric presentations such as coryzal symptoms, lower respiratory tract infections, tonsillitis and otitis media. Alongside this, many people came in with musculoskeletal back problems similar to the UK, and suprisingly a number had monthly blood pressure checks for hypertension. The prevelence of hypertension was a little suprising at first, however on reflection this could be due to the prevalence of smoking alongside the use of indoor fires flooding houses with smoke. The cigarettes were incredibly cheap in Cape MacClear- less than the price of a single bottle of beer, which no doubt contributes to this. They are also of worse quality, containing more tar and less nicotine, causing the users more harm. There was also a significant amount of asthma due to the dust, and potentially the passive inhalation of the indoor fires from a young age.

Despite the similarities, the clinic felt incredibly different to a GP practise in the United Kingdom for several epidemiological reasons. Firstly the prevalence of HIV was incredibly high, with all consultations including a check for a HIV test in the previous year. The clinic also recently opened a new wing allowing more space for HIV counselling, so any positive test was given same day counselling and invited to the next patient and guardian education session.

The snails of Lake Malawi are infamously infested with Bilharzia, and was the main source of bathing water for the locals and their clothes . Due to this, every consultation also involved a screening of the patients last antihelminth and deworming treatments. From a broader, public health perspective, deworming treatment was also given out at schools, and it was rare that a patient went more than 6 months without this.

Due to these two screening measures, it was rare to look through a patients health passport and see neither a HIV test, nor recent bilharzia treatment.

Malaria was also incredibly common, and anybody reporting a fever or displaying a temperature at triage was immediately sent for a malaria rapid diagnostic test before having a consultation with a doctor. It was interesting to see the flux of malaria prevalence during our short time at the clinic, as in our second and third weeks the number of malaria patients increased drastically due to local weather patterns. Most of the incredibly sick patients we transferred on to government hospitals in our time at the clinic had contracted severe or cerebral malaria, due to lack of response to treatment or presenting too late.

The population of Cape Maclear was largely formed of fishermen, who travelled from village to village around the lake. This fluctuating, temporary population gave birth to a number of nightclubs and a thriving bar girl industry. Due to this, sexually transmitted infections were among the most frequent of presentations seen at the clinic, including rarer diseases in the UK such as syphillis. Treatment was grouped into symptoms, and the clinic had a good protocol for education, condom dispensing and HIV checks when people presented with genitourinary symptoms.

2.What healthcare is available in Malawi, and how does this differ to Zambia and the UK?

Malawi and Zambia both have incredibly oversaturated government hospitals, with NGOs such as Billy's plugging as many gaps as possible. One of the most interesting contrasts was in the approach to payment. In the UK, we maintain a "free at the point of care" system, and pay for the NHS through taxes. In contrast, there was a single fee for an appointment at Billy's, however the majority of simple investigations, treatments or followup appointments were free. Livingstone Central Hospital in Zambia, on the other hand, charged nothing at casualty to be seen, however even simple investigations were charged for, such as a full blood count. X rays and ultrasound scans were even more expensive, and to fund an operation as a local was frequently crippling to a family. This more commonly reflected care at the local Malawian hospitals rather than the clinic.

3. What are the common presentations of HIV/AIDS in malawi and are these different to the UK? What are the local aims to treatment, and what treatments are available?

The care of the HIV patients at every stage was very impressive, and not what i was expecting to see. Due to the aforementioned very diligent HIV screening process, a far higher percentage of patients than i expected were diagnosed early, and subsequently put on treatment- similar to the latest UK HIV guidelines. All pregnant women were also screened for HIV, and mother to baby transmission rates were impressively low.

The Malawian protocols for ARVs were incredibly comprehensive and easy to use- probably designed to be used by a health care professional with limited training. It clearly outlined which medication to switch to in the event of an adverse drug reaction, and indicated any potential symptoms and side effects.

The aims for treatment in Billys were very time pressured due to the sheer number of HIV patients they were looking after. Instead of spending time counselling each patient individually, there were group counselling sessions with a trained professional who spoke the local language. Patient education and compliance were incredibly key aims for treatment- each month patients were instructed to bring their medications box, and the number of missed doses was recorded. To help with education and a patient centred care approach, each person was required to bring their guardian along to their appointment and the group teaching sessions to help the patient understand the importance of ARV compliance.

4.To be able to effectively work with a translator while adopting a good patient centered care approach, and maintain good rapport despite the language barrier

Working with a translator was one of the most rewarding challenges of Billy's Clinic. As we spoke little of the limited language, often we relied heavily on the translator to have a conversation and explore

the history of the presenting complaint. As these translators were not medical professionals, it was often difficult to work out what they had asked. Frequently I would ask about specific other symptoms, and the translator replied that the patient didn't have them without speaking to the patients first. This provided some challenges, and as the weeks went by, getting a better rapport with the translator helped make these clarifications easier. A good rapport with the translator also helped when taking sexual histories, and deferring to their judgement was often important. An example of this was that my most commonly asked question after asking a patient their number of sexual partners was "and do you believe them?".

The use of a translator also threw me when trying to build a rapport with the patients. The culture around healthcare was very different to what i was used to- the patient would rarely say hello and goodbye, and would talk to the translator directly rather than interacting with me. This was no doubt a consequence of being used to receiving care from doctors who couldn't speak the language. From observing other doctors, i noted ways to interact with the patient directly- particularly when examining them, that kept them at ease, and was respectful.