HIV

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Year 5

Elective Report: Rwanda

What are the common presenting conditions to the Rwandan GP clinic? How do these differ from the UK?

In many ways, the conditions that are most prevalent in the UK, namely: the common cold and viral upper respiratory tract infections (URTI), were also the ones that i saw most frequently in the Rwandan clinic. On the contrary however, such conditions were managed very differently in the two countries. In the UK, GPs are encouraged to limit antibiotic prescription to those with severe infection or those with secondary bacterial infection, and thus a patient presenting to a UK GP with typical viral URTI symptoms would often be provided with symptomatic relief only. In Rwanda however, virtually all such cases were prescribed antibiotics in addition to symptomatic relief. On asking doctors and nurses why they did this, they explained that many patients would not be happy without an antibiotic prescription and hence they did it to satisfy them.

In addition to this, there was also a higher prevalence in Rwanda of malaria and HIV. All patients who presented with flu-like symptoms were given a blood test for malaria, despite the fact that very few ever came back positive. With the GP practice also being a HIV centre, I witnessed a very high throughput of new HIV diagnoses, virtually all of whom had no symptoms. I also witnessed presentations of tropical diseases such as dengue fever and leptosporidiosis, that i have never witnessed in the UK.

Finally, there were also a great deal of patients who, in similar frequency to the UK, came in to seek healthcare related to a chronic condition such as diabetes, hypertension and depression

How are GP services organised in Rwanda? How do these differ to the United Kingdom?

With respect to primary care, the UK and Rwanda have some similarities. A patient always sees a doctor or nurse at the local health clinic first and, if necessary, they are then referred upwards to a specialist. How this differs between the two countries however is that this rule applies to every condition in Rwanda, no matter how critical, as there is no Accident and Emergency. Thus, a critically ill patient would need to be taken to the local health clinic first before

receiving a transfer letter to the hospital. An example of this that I witnessed was the case of an 18 month old child who was unconscious and had a fever at 41 degrees. I found it extremely frustrating to see a child that needed to be in hospital urgently to be at the health clinic where appropriate provisions were not available.

Because of the above legislation, patients who needed hospital care often instead received sub-optimal care at the health clinic. An example of this was the case of a middle aged asthmatic lady, who had presented with extreme shortness of breath and an inability to speak. As the clinic had no oxygen facilities, inhalers or nebulisers, which are the first line treatments for acute asthma in the UK, the patient was immediately given an IV bolus of aminophylline. This was unsuccessful and thus she was finally transferred to the hospital. By not being able to seek specialist help early, this made the asthma attack much more traumatic for the patient than it should have been.

How are HIV services organised in Rwanda? How do these differ to the United Kingdom?

New HIV diagnoses in the UK and Rwanda are made in a relatively similar manner. The majority that I witnessed were of patients that had come to the health clinic with the view to having a test. Many did not have any symptoms, nor did they expect that the test would come back positive. The health clinic that I attended were excellent at educating the local community on HIV diagnosis, and several times a week a social worker explained the importance of testing to large groups of people. Because of these sessions, many people attended every day for testing, enabling new diagnoses to be picked up early. I cannot say that I have witnessed such things in UK health centres.

Post diagnosis, patients in Rwanda are invited to counselling sessions with specially trained support workers and are then advised to see the doctor regarding treatment. Patients are then monitored yearly for their CD4 count and their viral load. This is all almost identical to the services provided by the UK.

Where the UK and Rwanda do differ significantly however is with regards to treatment. In the UK, treatment choice is generally based on a combination of effectiveness, ease of use and side-effects, whereas in Rwanda it is more heavily based on cost. The use of polypills that are loved by UK HIV patients would not even be considered in Rwanda. Instead, physicians commonly tend to prescribe drugs such as Stavudine, that are cheap but also come with a lengthy side effect profile. It is hence not surprising that I saw many patients attend clinic complaining of side-effects.

What has this experience taught you about being sensitive and non-judgemental towards patients with HIV and in general?

Associated with HIV all over the world is a tremendous stigma and I found this to be no different in Rwanda. On speaking to patients with HIV, they described being rejected by both their communities and long term partners, and feeling incredibly low because of their condition. Some patients were travelling across the whole of the country to attend their HIV clinics so as to avoid their community finding out their diagnosis. The very distress of these patients regarding their condition highlighted to me the importance of the healthcare team in reducing anxiety. Indeed, for a lot of patients, they feel judged by everyone and the healthcare team are the only people they feel that they can talk openly with about their HIV. Being particularly sensitive with such patients allows this openness to happen.

I found the importance of such communication skills to be especially important in Rwanda where, unfortunately, keeping their diagnosis a secret becomes problematic for a significant number of patients due to treatment with Stavudine. Stavudine causes noticeable facial lipoatrophy in many patients and, because of this, they almost become labelled with HIV. Indeed, it was possible to spot some HIV patients without even speaking to them, and this can only go to further stigmatise the condition.

The doctors and nurses at the Rwandan clinic made sure they had a lot of time for their HIV patients so that enough time was allowed for them to resolve any concerns and subsequently give them a little bit of control over their condition.