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Elective report

Objective 1: Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health.

Uganda, as with many countries in this region, faces a huge burden of communicable diseases, notably malaria and this has been reflected with the types of patients I have been seeing. Although it is said that Kampala itself is not a prevalent area for malaria, there are still many cases of admitted everyday at Mulago hospital. The infectious disease team at the hospital are generally very good at diagnosing and treating the disease, although due to the many different presentations of malaria and the length of time people spend before attending hospital, there are still many mortalities.

There remains a huge burden of HIV and AIDS in the country, which contribute to the country having one of the lowest life expectancies in the world, at 54.07 years compared to 80.75 years in the UK. This is reflected in what I saw on the wards. Every specialty I was placed with, there were patients due to complications of HIV/AIDS. What I did notice, which was very encouraging, is that all antiretrovirals were free for all patients and this not only includes the multidrug antiretrovirals but also septrin (cotrimoxizol) as pneumocyctis (PCP) prophylaxis. However, due a multitude of factors patients often have very low CD4 counts at diagnosis and therefore the mortality is still very high.

Objective 2: Describe the pattern of health provision in relation to the country in which you will be working and contrast this with other countries, or with the UK.

Unlike the UK, much of the healthcare provision in Uganda is made in the form of 'out-of-pocket' payments which are often financially catastrophic for families. This often includes common investigation such as bloods and CXRs. This means that if families are too poor to pay, the diagnosis is often not found and treatment not sort after. Only the very common, often older drugs are free. I was therefore very shock to find out that almost every patient who is admitted to the A&E department received metronidazole irrespective of the reason for admission.

There was often a lack of resources on the wards. For example a full blood count is free but one of the two machines which give the results broke for the whole time I was there which means that patients were often waiting for days to have their FBC assessed. To make things worse the machine that broke was the free machine which meant that if patients wanted to have their FBC assessed they would need to pay for it. Another example I saw was the lack of ECG machines in the hospital. There was only one machine in the whole hospital which only one trained professional can use. This led to several cases of cardiac ischaemic event being missed.

The level of staffing within the hospital was also something which was very different to the UK. I noticed a distinct lack of nurses on the wards. In fact the

wards were packed with relatives who acted as the nurses feeding and cleaning the patients. When we first got to the hospital all the junior doctors were on strike, as they haven't been paid for three months. This meant that there was a distinct lack of doctors on the wards. The ward rounds would last many hours and the jobs would take days to complete, all of which was at the detriment of patient care.

Objective 3: Health related objectives

I am very interested in Cardiology so during my time at Mulago hospital I spent a large majority of my time on the cardiology unit. There was a disease that I saw which was very interesting. It is call Endomyocardial Fibrosis (EMF) and it is found predominately in central Uganda alone. Patients often presented with overt heart failure and theres no known causes of this disease. The patients are often very young and the disease is normally at an advanced stage at diagnosis. The treatment is generally conservative which means that there is significant mortality.

Another thing I noticed on the cardiology unit is how prevalent hypertension is in the young male population. The average age of diagnosis was around 35 years and some patients were at end stage hypertension at diagnosis with significant renal failure. The treatment regimes were different also. The main driver for prescriptions is cost of the medications. The main drug for the treatment of hypertension is captopril, a drug that is very rarely used here in the UK. Another issue the patients have is iatrogenic causes of hypotension. When patients are diagnosed with hypertension they are prescribed medication from multiple sources and due to a lack of communication between different healthcare professionals and a lack of understanding from the patients themselves, they end up being admitted to the hospital which takes up more resources.

Objective 4: Personal/professional development goals. Must also include some reflective assessment of your activities and experiences.

I am a very keen teacher so when the opportunity came to teach the local doctors I jumped at the chance. During my time on the cardiology unit I got the impression that the SHOs on the ward had a very basic knowledge of reading ECGs. I went through the basics with them and taught them a system of reading the ECGs so they don't miss anything out. They gave me some really good feedback which has really helped me with my confidence with teaching.

While I was there I was also able to witness some procedures that I have not previously done so. These included a pericardiocentesis and lumbar puncture. It was very helpful as the doctors talked me through what exactly they were going to do before they conducted the procedure and why exactly they were doing it.

Overall my placement at Mulago hospital, Kampala, was excellent. I experienced a wide range of specialties and saw some very rare diseases along the way. It was very interesting to see the ins and outs of a different health system and also the challenges of healthcare in a developing country.