Yousuf Sabah

Elective Report

1. *To investigate the prevalence, presentation, diagnosis and treatment of parasitic diseases such as malaria and fungal infections.*

Malaria was a concern of ours before leaving for the amazon and we were all stocked with malaria prophylaxis, however we did not encounter one case of malaria during our trip. The local doctors on the trip told us that they only see a few cases of malaria each year.

Fungal infections and parasites were amongst the most common conditions that we saw during clinics on our elective. Parasites are a large problem in the Amazon, due to the lack of clean drinking water. Every patient that came to clinic was given an antiparasite medication at medication, and additional tablets given to them for members of the family who were unable to attend. It was very common to see patients with fungal infections, particularly ringworm however it was not always possible to make a definitive diagnosis and a general antifungal medication would be administered.

2. *To understand the health provision available to residents of the Ampiyacu River.*

The health care facilities available along the river varied depending on the size of the village. The last major town before going further into the Amazon, Pevas, had a health centre with doctors, nurses and technicians. Villages further from Iquitos into the Amazon did not usually have a centre, only the larger villages had a technician, which was in contact with the clinic in Pevas, trained to treat minor injuries and conditions.

Anyone that was severely unwell would have had to travel to Pevas to be seen, however the clinic there still only had limited facilities and would probably have needed to go to Iquitos to be seen in hospital there.

Peru's healthcare system operates with a mixture of state and private health insurance. People have to be registered into the state health care system, which may not cover all of their medical treatment, there is a limited number of conditions and available treatments on the state scheme. Things like travel costs and accommodation are not covered in the state scheme, with some of the villages along the river over a day's trip on a boat to Iquitos, where the nearest hospital is, transportation costs alone can be financially crippling for these people.

3. *To explore how the indigenous populations healthcare beliefs interact with western medicine*

The indigenous population in the Amazon were very receptive to Western medicine and the majority of patients were eager to see us in clinics. When dispensing medication from the pharmacy patients were keen to try and receive injections, speaking to the local doctors we established that they seem to believe that injections would be more effective in treating them. Throughout the trip we had to

explain to patients that tablets would be effective in treating them and would work in a very similar way. As the local health care provision is somewhat scarce and overwhelmed where it is available it was important to try and educate patients about their treatment, as it would not be possible to give patients injections everyday to treat conditions that could easily be managed with tablets.

It was also apparent after a few days of running clinics that a lot of patients seemed to be merely stocking up on medications they might need for the year ahead, a lot of families would come to clinic with each child having a different presenting complaint, on examination a lot of patients were found to be well. After a few days it was decided to give medication to the families with advice to keep the medicine until they were actually needed and to speak with the technician in the village to help them.

4. *To broaden and enhance my awareness of medicine in challenging environments and contrast it to care in the UK.*

The majority of clinics that we ran during the elective were held in the village school, generally a large room in one of the buildings in the centre of the village. Desks were setup for us to use as areas for examining and dispensing medications. There was very little privacy for patients and consultations were not exactly confidential as people were generally waiting in very close proximity. This is vastly different to the health care system we are used to back at home, where we usually examine patients at least behind a curtain or in clinics a private room. Differently to back in the UK where women, in particular, are not comfortable to talk to male doctors and medical students, it was on the whole not too big an issue; however there were some cases where patients did want a bit of extra privacy or to speak to a woman.

There were no real investigations available except for urine dipsticks, practicing in this way is again quite different to being in the UK. Despite the lack of investigations it was still possible to treat patients empirically, relying on your clinical judgement to derive a diagnosis and treatment plan.

Working with a limited supply of medication was also very different to being back at home, when dispensing medication we had to be aware of the number of clinics we still had to run on the trip. At home we work with what seems like an unlimited supply of medications, with pharmacies in many cases being able to order and get medications on the same day for patients. Working with a limited supply meant that we could only supply a small amount of medication to patients, this did not seem to be a problem for the treatment of acute conditions but it was not possible to supply enough medication for long term treatment. Management of chronic conditions seemed quite problematic in the Amazon, due to the remote nature of the villages and the lack of healthcare infrastructure. At the end of the trip we completed an inventory of what had been used on the trip for stocks to be replaced, it was a real shock to quantify the amount of medications we had used over the course of the trip. In addition to this we also made suggestions of other medication to add to the stocks that the boat keeps.