Elective Report

Emma Withycombe
Ndi Moyo Palliative Care Centre, Salima, Malawi.

What are the prevalent palliative care conditions in Malawi and how do they differ from the UK?

The palliative care conditions seen in the UK and Malawi are very different. The patients in Malawi are generally younger and a large proportion of patients have HIV/AIDS. The most common condition seen at Ndi Moyo is Kaposi's Sarcoma, which I had never seen in the UK. Kaposi's Sarcoma is a cancer of HIV/AIDS affecting the lymphatics and skin. Many of the patients with Kaposi's Sarcoma are young, and with HAART and chemotherapy it can be stabilised, controlled and sometimes cured.

The other main conditions seen are cervical cancer, hepatocellular carcinoma and oesphageal cancer. These are often seen in HIV positive patients, but also in many patients who are HIV negative. High cervical cancer rates are probably due to high HPV infection rates and lack of screening programmes. High hepatocellular carcinoma and oesphageal cancer rates may be related to alcohol intake. Hepatocellular carcinoma could also be related to exposure to aflatoxin in peanuts and oesophageal carcinoma rates could also be related to H.pylori exposure.

In the UK, palliative care is broadening to routinely include non-cancer patients. Ndi Moyo currently has very few non-cancer patients and initially they specifically only targetted cancer patients because this is much simpler for patients and healthcare providers who have often never heard of palliative care before.

In terms of the most prevalent symptoms, I was struck by the lack of nausea and by patients' resiliance to pain. In the UK nausea is often a very difficult symptom to manage towards the end of life, but in Malawi it is usually only reported when due to squashed stomach syndrome. Patients with even the most disfiguring conditions would report no pain, or pain completely controlled with paracetamol.

How are healthcare and social services organised in Malawi and how do they compare to the UK?

In theory healthcare in Malawi is free, provided by the district hospitals. The care at Salima District Hospital, which we frequently visited, was appalling. There was one doctor at the hospital, who I never met in the 6 weeks I was there, and none of the healthcare professionals that I met ever knew what was going on with any of our patients. The beds do not have sheets and patients lie on the mattresses with open wounds and there was no real record of which medications or fluid had been given or prescribed. In the 6 weeks that we visited Salima District Hospital I only saw one patient improve and that was because Ndi Moyo brought him antibiotics for him to take himself. Everyone else was either discharged in the same or a worse state or died.

The central hospitals in the main cities in Malawi seemed much better equipped. They are set up as teaching hospitals and often provide a much better level of care than the district hospitals. However, it is expensive for patients to get transport there and they are often extremely overcrowded and still very limited in their resources. For example, there in no radiotherapy available in Malawi, therefore any patients with spinal cord compression can only be treated with steroids.

There are a number of private clinics, NGO clinics and missionary hospitals. The notes from private clinics often had very strange diagnoses and the regulations for setting up a private clinic seemed to be very loose. The missionary hospitals and NGO clinics seemed very competent but many charge a small fee to try to ensure that their services are sustainable and this is often unaffordable for many Malawians.

Social services do exist but hugely limited in their capacity and have very little power. Ndi Moyo offers social services which far exceed any other organisation encountered, for example they offer comfort funds for transport, etc.

Witch doctors are still a large part of Malawian culture. They are not illegal unlike in other African countries, and they are usually accessible for even the most rural Malawians. They are intergrated into the culture and even many of the highly educated Malawians I met still believe in witchcraft. However, they contribute highly to morbidity, stigma and mortality. Patients often turn to witch doctors either before healthcare or when other healthcare options fail. They can leave patients with horrific effects from attempted treatement and contribute towards late presentation.

What are the added challenges faced by palliative care in Malawi compared to the UK?

The most obvious added challenge is a lack of resources, the pharmacy at Ndi Moyo has a very limited number of drugs. While this made getting to know the common prescriptions relatively easy, often the most basic drugs that you might turn to in the UK were not available, for example salbutamol inhalers. It was very frustrating to have the knowledge but not the means to help people, but sometimes it was about learning the alternatives used, for example artemisia plant ointment for skin fungal infections when topical antifungals were not available.

Even when appropriate medications are available it was very difficult to ensure that patients were taking them appropriately. Very few of the patients are educated beyond primary school and few can read or write. Few patients own a watch or clock and few patients have a light at home. Therefore, it is difficult for patients to manage using a syringe to withdraw and take the correct dose of morphine at the correct time at night without even a table to use as a flat surface.

Cultural differences and attitudes towards death and illness are an added challenge for those used to working outside of Malawi. Death in Malawi is completely taboo and attempts to broach the subject of prognosis or death and dying are often interpreted as witch craft and you willing the patient to die. Illnesses are often seen as due to witchcraft directed by enemies, and patients and their families often look to those around them to blame for their suffering. This can cause divides within families at a time when that support is most needed.

How am I able to cope when confronted with extremes of poverity, suffering and inequality?

I was strongly affected by some of the patients I met. I think that partly because for many I knew that a lot of the suffering was unecessary. I knew that if they were in the UK with the same conditions they would live. I met a number of patients who had become unwell and terminally ill due to non-compliance and I found these situations very frustrating. Malawi is famous for being a laid back and relaxed country, exemplified by its lack of violence, but I found this fatalistic attitude towards illness and healthcare confusing. I think that I would always struggle to grasp many aspects of the culture but I found Malawi a fascinating country and I would love to come back to work somewhere like Malawi in the future.