PYSCHIATRY

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MEDICAL ELECTIVE REPORT

ALL IN THE MIND?

When planning my elective in Uganda, I wasn't quite sure what to expect, be it from the healthcare service or the patient population. Knowledge of the physical health in the less economically developed world is generally available. Less information is available regarding mental health and the challenges that come with it.

Sadly, Uganda is no different from the rest of the world with mental illness presenting a significant public health concern. Despite this, there is a distinct lack of literature available to both quantify and qualify this burden of disease.

Barriers to accessing healthcare

Estimates suggest that at least 35% of Uganda's thirty-one million population suffer from some form of mental health disorder. With only twenty-eight psychiatrists serving the entire nation; it seems that the stigma associated with mental health extends to health workers as well as patients and their families. According to the 2008 mental health and poverty project, health workers are reluctant to specialize in psychiatry because of the stigma associated with mental illness. During my time with a cohort of medical students on their psychiatry rotation, it was quite clear that the prejudices seen amongst medical students in the UK are also prevalent in Uganda. On the other hand, with time, I was reassured to have students confess their realizations of their prior prejudices and their newfound appreciation for patients with mental health disorders to be just like 'any other sick patient'.

Attitudes in the community however may prove more resistant to change. African culture is renowned the world over for its depth. It has many merits and has taught me a lot during my time here. Alas, it also offers various explanatory models for disease processes that can do more harm than good. Mental health disorders are often attributed to bewitching or demonic possession, with the relevant traditional therapy ensuing. Owing therefore to both the inaccessibility of mental health workers and such deeply rooted explanations of disease, together with resolute claims of the proven successes of traditional treatments pit against the 'failings' of modern medicine, it is no surprise that approximately 80% of patients with mental health disorders frequent traditional healers. As a result, patients present to services late, if at all, with advanced disease processes that are challenging to treat. Furthermore, with little regulation of the practice of traditional healers, coupled with the availability of potent psychoactive medications over the counter, many patients who are receiving psychiatric care run the risk of dangerous drug interactions.

Reassuringly, my time with the village health team (VHT) based at Kinoni health centre IV demonstrated that an awareness of the burden of mental health disorder is penetrating primary care in Uganda. Introduced in 2007, VHTs comprise volunteers selected by their

communities to provide accurate health information, mobilize their community and facilitate the all-important link between communities and health services. The volunteers serve to monitor the health of their village and act accordingly, be it dispensing medicines supplied by the health services, educating the people on basic illnesses and their prevention or identifying danger signs in unwell patients and making an appropriate referral. Although they are primarily aimed at containing infectious diseases and improving maternal and child health, they serve a wider role as the eyes and ears of the village. Their familiarity with traditional healers practicing within their community and the health services available are fundamental to improving access to health services. It was particularly encouraging therefore to see that a significant proportion of the refresher workshop I attended was dedicated to an update on how to access the mental health services available in the area.

Moreover, by using respected and trusted local volunteers, the VHT strategy will hopefully overcome the previously insurmountable stigma, fear and distrust associated with health services that can be so damaging to mental health rehabilitation.

Of course resource limitation is not limited to workforce alone, with a lack of funds taking its place as an ever-present barrier to accessing healthcare.

A significant proportion of patients with mental health disorders will require lifelong treatments that are rarely afforded by the health centres or the patients themselves. Those that can afford their treatments are limited in choice by the older and hence cheaper therapies that bring with them a potentially harrowing side-effect profile; often enough to dissuade patients from continuing with their treatment and revert to traditional methods.

Although Ugandan economics has not experienced a miraculous boost, mental health services have seen an injection of funds in recent years, with several new regional centres founded across the country in order to improve access to services. Similarly, the country's essential drugs register currently includes an, albeit limited, selection of psychotherapeutic agents.

In saying this however, simpler financial challenges include the fact that many patients cannot afford to frequent the services they are referred to. With poverty so intimately linked with poor health, many patients will prioritise a money-making opportunity over an outpatient appointment. Although some VHTs provide follow-up services as part of their outreach, they too are reliant upon voluntary donations and are thus not uniformly available.

Global Responsibility

Knowledge is power, so the old saying goes. With power however comes great responsibility. As the mighty force of globalization blurs the boundaries between nations, the question arises; how do we, as a unified collection of healthcare professionals tackle the global burden of mental health?

As a proud Bart's and the London SMD student, I was pleased to see the link between Butabika hospital and the East London NHS foundation trust (ELFT) in action. Set up in 2004, the partnership serves to help build the capacity of the under-resourced Ugandan mental health service, through the sharing of experiences of practice and systems organization and development. Through several exchanges Ugandan staff members have been able to access training and professional development at centres in the UK, complemented by lectures and programmes organized by ELFT for doctors and medical students at Butabika. In turn, experiences from Butabika have been used as part of the training and continuing education of healthcare students in the UK regarding issues such as the promotion of innovation and cultural awareness. Such collaborations therefore equip both parties to cater for the specific needs of their service users in a more effective manner, ultimately understanding their patients better, and optimizing services accordingly.

By taking on their wider social responsibility, the ELFT have also potentially inspired their Ugandan counterparts to do the same. When discussing the VHT project with the training co-ordinator, I was intrigued to understand why the volunteers were willing to take on the roles that they have. Her personal response was that if people at the University of Calgary thousands of miles away can sympathise with the Ugandan people enough to fund such a project, her own sympathies should also spur her to work for her people. So she did- and is doing a great job at that.

Conclusion

Irrespective of my prior expectations, I leave Uganda with a newfound awareness of my role as a healthcare professional in breaking the barriers to accessing healthcare. Whilst the country's size and rural population are contributory factors, small scale examples have shown that the principles of education and outreach stand tall as potential solutions. The onus is now on the Ministry of Health and medical professionals on the ground, worldwide, to transfer these projects into sustainable policies and nationwide projects.

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Elective: Fiji May 2011
Barts and the London Medical School

Medical Elective Report

Objectives

1. Describe the pattern of health provision in Fiji, and Levuka. Compare & contrast this system of healthcare with the NHS.
2. Describe the pattern of illness/disease in Fiji, and Levuka hospital. Analyse this in the context of global health.
3. Describe maternal healthcare in context of Fijian culture.
4. Practice diagnostic & practical skills. Reflect on my elective experience.

Introduction

My elective placement was in Levuka Hospital on the island of Ovalau in Fiji. During my five week placement I learnt a great amount by working in the outpatient department, through ward work and community visits. In this report I will outline my experience and discuss the first two objectives, health provision and pattern of disease in Fiji.

Elective Experience

Levuka hospital had two doctors, Dr. Kali and Dr. Mere (who were both in their second year out from university, equivalent to FY2 in the UK). The hospital duties were divided between them so that one doctor covered the ward while the other saw patients in the outpatient department. I attended the ward round in the morning at 8am reviewing patients on the ward and discussing difficult cases and doing procedures (cannulation and placement of catheters), which was similar to the UK. The doctors explained how different cases were dealt with. The hospital has a limited lab, which can process full blood count (FBC) and urea and electrolyte (but only sodium and potassium values). Imaging in Levuka hospital is confined to x-ray and ultrasound (the ultrasound machine was actually donated by previous elective student from the UK). The constraints of limited investigations dictate the course medical care in Levuka hospital. Treatment is initiated upon clinical suspicion instead of biochemistry or imaging proof, which is very different from the UK. Doctor's expertise and experience was greatly relied on as they had the responsibility of initiating emergency transfer of patients. Admission to the hospital was dependant on the severity of the case and patients address (as links between Levuka and some villages was difficult). Throughout my time at Levuka I experienced hospital life, and was no duty during the evening and night time if there was a birth happening. Furthermore, there were many cases of circumcision during the Easter school holidays. Under Dr. Kali expert guidance I was able to learn the procedure and carry one out independently.

Apart from ward work, I attended the general outpatients department (GOPD) starting at 8am. I examined the patients independently and prescribed the necessary medication, nursing care or investigation, as was expected of medical students in Fiji (and exemplified by our Fijian colleagues). Initially, my level of responsibility at Levuak compared to the UK was great (and daunting). However, the doctors and Fijian medical students were always at hand to consult, making the transition of my role between the two countries easier. The main learning point for me was taking sole responsibility for patients and the ability to ask adequately for help. Furthermore, I learnt how to prescribe in a different country (which had the constraints of limited resources). Thus, during my time at Levuka GOPD I took that initial step from medical student to junior doctor under expert guidance.