Malawi Reflection

Having grown up with the constant feeling of having an itch that needs scratching, when Katy suggested working with AMECA I had no hesitations about getting involved. Having previously worked for a travelling doctor in northern Thailand, serving refugees of the Burmese civil conflict, I knew I enjoyed the challenge of working in resource poor environments and was keen to have another bite of the cherry. Despite it being on my bucket list for a long time now I'd never been to Africa and couldn't refuse the opportunity to experience the culture I'd heard so much about. The team consisted of a group of junior doctors from Croydon and a plus one I was very grateful for the company of (as his presence meant I wasn't the only man on tour!).

It didn't take us long to establish that we knew very little about Malawi's healthcare system. After an introductory meeting with Ruthie Markus, CEO of AMECA and Paul Thomas (AMECA's Medical Director) a feeling of excitement surged around the group as we began to realise we had a clean slate to work off with a respectable amount of autonomy. Ruthie was palpably passionate about the clinic but with her efforts focused on the logistics of the project, she wanted a group of medics to lead the clinical charge. She wanted us to design a project that would allow the clinic to better understand the health needs of its populous. By nature we were an inquisitive group and I must say the more we planned the more questions we unearthed. The prospect of so many unanswered questions was intimidating but not the kind of overbearing intimidation that often sees a good idea lay to waste. By nature of the group the intimidation turned into a challenge and so the spark was lit for our Malawian adventure!

When you don't know much about what you're going into, the amount of planning you can do is unnervingly minimal. We stumbled forward with the logistics but struggled to conceptualize exactly what information we needed to collect. Aware that we had a very brief two week window within which to obtain the data, we decided to touch superficially on a number of areas, including: basic demographics of the population, HIV, immunisation and vaccination status of their children. We also thought it appropriate to scope into maternal health as a priority area for the population and clinic alike.

Our first week was spent meeting key stakeholders in the project, representatives from the Department of Health, the village chiefs and our local translators. As each group described what healthcare in Malawi meant to them, the focus of our project became clearer. With one voice, the government clarified the theory behind the structure of their system and another the people explained the reality. As a student I did a B.Sc. in healthcare management and am particularly interested in business management and entrepreneurship. For me this part of the trip was fascinating. Having to tease out the relevant bits of information from people who didn't always speak the same language, whilst working in a group who didn't know each other particularly well was, at times, a challenge. Much like what I'd imagine being a management consultant would be. I like to work with structure but when there are so many unknowns, structure is nigh on impossible. We felt our way forward with each meeting, the further we went the more cohesive we became and by the end of our first week we'd nailed down our survey questions and begun to gel as a team.....time for a well earned break!

Our weekend was spent exploring the summit of Mount Mulanji and getting stuck in the mud on Safari at Liwonde. Climbing the mountain was good fun. We only went to the summit but if you fancy something more physically exerting the peak is always an option. Porters will carry whatever you give them, sometimes with no shoes on (making you feel very much surplus to requirements!) or you can take your own bags and skip up to the top. There we found our cabin with naught but a few beds and an open fire; a good escape from the WiFi. With beautifully clear skies, after a few beers and some heated debate about the challenges of dealing with mental health in the community (lots of medic chat!) we dragged our mattresses outside and continued our beverage consumption and highbrow conversation underneath the stars. Liwonde was cool. I'd never been on Safari before and the volume of wildlife surprised me - hippos playing in the shallows, crocs slithering off whenever in sight and a family of elephants feeding in the marshes, all as you'd imagine.

The majority of the second week was spent collecting data in the villages. The chiefs were very accommodating and most had done a good job of rounding up the pregnant women. To AMECA's credit the relationships Ruthie has built in the community opened doors for us and will do so for future projects.

The sheer volume of work that needs doing out there is astounding. Listening to the women describe how they have given birth on the road side mid way through their two hour hike to the clinic puts our western dilemmas into perspective. A huge frustration I have working in the NHS is the amount of chefs trying to cook the same broth. At times if feel we do projects just for the sake of doing projects and on reflection I wonder how much impact any the ones I have worked on have actually had. We're caged into a box of safety, so much so it's difficult to spot weaknesses in the system on which we can work. So much talent amongst us, but such little scope to exert it. Not so in Malawi. Children eat dirty mangos from under the tree, women don't take folic acid during

pregnancy, they fall pregnant unintentionally for a whole host of reversible reasons; clinical officers overload the district hospital with unwarranted referrals, to name but a few things that spring to mind. All of the above can be avoided with simple interventions, many of which volunteers can play a part in. There are of course limitations imposed upon quality improvement that are out of our control, the country has very few natural resources and thus money is restricted and there are whisperings of corruption and bribery still being common practice amongst officials. None the less AMECA strictly takes no part in any of these activities and the villagers we came across all seemed sincere in their desire for better provision of services in the region. The villages provided me with a brief snapshot of what life is like in rural Africa; hot, dry and dusty but full of life. It will take time for AMECA to fully quantify the health needs of its population. Our venture was but a spot on the horizon, from which I hope AMECA will begin to build a comprehensive data set about the population. I hope we have begun to build the foundations on which this can be laid.

We have not yet formally collated our report but my gut says there will be several key points for the clinic to work on over the coming months; acquiring funding to enhance maternity services will almost certainly be a priority, each area of service provision including immunisations, vaccinations, HIV management and basic patient triage will need to be scrutinised. A concern of mine is that these services will be established but not embedded into the community. Their introduction will need to be partnered with a comprehensive educational program for uptake to be effective.

Malawi doesn't have a public record of health data. Come to think of it the UK is struggling to get its population onto one platform. The market is compartmentalised into programs which each serve their respective purpose - one program for imaging, another for bloods another for note taking etc... One of the key challenges we face in understanding health data is pulling it into one platform. From there the potential for understanding is limitless. Research would be streamlined without academics having to interrogate various different systems for their data. Perhaps in the future a computer

could 'understand' a single data set without human input. The challenges the UK has faced introducing such a program have been more political than technical. We spent 13B on the national program for IT and weren't able to understand the needs of each user group well enough to program the desired functions into one program. The technology is there, the market is ripe for a single computer program to store and begin to understand a nations health. An emerging market, unspoiled by the imperfect efforts of the big technology companies is a prime area for it to emerge. A pie in the sky dream would be to see the clinic, with government support, design a computer program that could store all of its patients data and provide an all inclusive service for healthcare users. From basic demographics when a patient first registers with the clinic, through to ordering and publishing results of investigations, requesting and prescribing drugs, booking appointments etc. Perhaps a little ambitious but this is the future of healthcare, why not start here?

The clinic has gone up faster than any other in the region under Ruthies stewardship. She has the connections and importantly governments trust in her to get the job done. With them on board and support from the community, this project has the potential to evolve into a model for the future, a flagship clinic that others can be modelled upon.

"I am very grateful for the support given to the team by AMECA, being in a small group in foreign territory comes with its own intimidation factor but Ruthie worked tirelessly to facilitate our efforts and make our path as smooth as it could be. Without this it would not have been possible to achieve what we set out to do."

George Ryan.
Junior doctor.