International Travel Scholarship Report

Bwindi Community Hospital 2017-2018

Bwindi Community Hospital (BCH) is a uniquely charming healthcare facility in South Western Uganda set between two UNESCO world heritage sites and at the foothills of some of Africa's most breath-taking mountains: the Rwenzori mountain range (local translation – the 'rain-maker' mountains) and the Virunga mountains - a volcanic mountain range which is a branch of the Albertine rift valley. At the doorstep of the hospital is the Bwindi Impenetrable Forest – home to over half the world's population of critically endangered mountain gorillas, as well as the highest concentration of tree species anywhere in the world. It has also been from this forest that over the last two decades the Batwa pygmies – a population of indigenous forest dwellers have been displaced and are now attempting to integrate with some 100,000 locals from the Bakiga tribe – who together form the hospital's catchment population. The economic reality of this population is depressingly stark with most families living on less than a dollar a day which is further compounded by numerous real health risks such as zoonotic diseases, a high prevalence of HIV and malaria, as well as the looming threat of Ebola from the nearby border it shares with the DRC – less than 5km away.

It has been amongst the backdrop of this spectacularly diverse biological and geological landscape where I have had the good fortune to spend the last 14 months with my wife and two young boys (2 and 3 years old). I worked as a Volunteer Family Physician with the RCGP International Partnership at BCH in what has been a thoroughly enjoyable, challenging, and all-together formative experience.

I have been increasingly interested in the role of primary care in global health through previous shorter experiences I have taken abroad during and after graduating from medical school around 10 years ago. As a newly qualified GP I felt passionately that there were a lot of transferrable skills I could gain through a role such as this and through the partnership with the RCGP I saw the opportunity to help effect real sustainable change across global borders. The scheme also fitted well with the UN Sustainable Development Goals for 'Health and Wellbeing' and related closely to the ethical duties of a healthcare professional. My wife who is from South Africa was longing for a more wholesome and outdoor lifestyle for our two boys, and her background in sustainable energy engineering opened our eyes to the challenge of breaking away from the cycle of consumption and the unmetered impact of the high energy use embedded within our lifestyles here in the UK. After reading through the job role and discussing the opportunity back and forth a few times, we started to appreciate what value this year could bring not just to me professionally, but to us all as a family.

Day to day I had clinical responsibilities on the Adult Inpatient Ward three days a week treating patients with tropical and infectious diseases, as well as chronic diseases which are often poorly managed and unfortunately increasing at an alarming rate. I engaged in doing practical procedures from assessing patients in remote locations with little equipment, to regularly taking ECGs, doing lumbar punctures, paracentesis, cannulation and doing lab-based microscopy and rapid diagnostic testing. This alone starkly contrasts with the day to day work in the UK. Further to this role, for the remaining three days in the week I had dedicated time to

focus on quality improvement which is where I felt I was able to make the most impact and where the hospital benefitted from the longer-term sustainable change through the partnership.

During my quality improvement time the key areas I was involved with were teaching and mentoring, audits and case reviews, input at management meetings and many more indirect quality improvement activities. The teaching and mentoring took the form of lecturing on palliative care at the nursing school, bedside teaching during ward rounds, mentoring and teaching students and staff, and co-ordinating clinical activities for overseas medical volunteers. The audits focused on quality of inpatient care, death audits and perinatal mortality and morbidity case reviews. During the management meetings we reviewed the hospital formulary, reviewed treatment guidelines for various conditions, organised surgical camps, and discussed infrastructure projects. In addition, along with other clinical departments I helped to create resources for diabetes awareness and family planning (adapted specifically to the local language and culture), as well as filmed and produced two health awareness films/plays. The more indirect quality improvement work I did took the form of designing and applying for funding for new hospital buildings and helping to improve the quality of data collection through a significant upgrade to the electronic medical record system and finally, helping to create a new system to digitise patient records and X-rays to enable easier research, and remote consultation in challenging cases.

I found it challenging to see how those who could not afford simple treatment were turned away to die. Yet within this environment, at BCH, there is an innovative community health insurance scheme which tries to promote better health seeking behaviour by subsidising early consultation. The impact of the scheme is that even with very little money (about £6 per year per family), some of the poorest of the poor can take ownership over their health and benefit from high quality, evidence-based interventions and health education. Seeing the impact of this, I can better appreciate the value of our NHS, how important it is today within the NHS that we do not discriminate between patients when offering new or existing services, and how it is important to study your practice population and their consulting habits to help better customise delivery of healthcare.

Another key reflection is how similar the challenges are in healthcare delivery both within the NHS and at BCH - I can recall many times here in the UK how the lack of financial resources within the NHS is often cited to justify why a service is under-performing. At BCH I experienced so many low-to-zero-cost solutions where we saw significant improvements in quality of care and now, I am convinced that, despite the resources available, quality improvement must be an essential part of any clinician's role.

From the day we arrived in Bwindi, I never looked back. The experience was all I hoped it would be and more. We found the people to be some of the poorest we had ever encountered in terms of wealth, yet they were the richest we have known when it came to community, friendship, warmth and generosity. The challenges we came up against taught us things we never expected – how to navigate a Ugandan Wedding ceremony, how to make home-made chapattis when all the stalls close and the nearest supermarket is 3 hours away by road, how to drain the fuel tank when

the fuel attendant insists your car takes petrol rather than diesel, and most especially how to be a human being and maintain that patient and colleague relationship despite differences in colour, class, language, literacy and culture. Those universal non-verbals of laughter, smiles and tears were more bonding than any amount of consultation model theory and helped me to realise that after all the guidelines, budget reviews and target chasing, medicine, just like life, revolves around one key thing – relationships.