

Out of Hours

The role of GPs in the world's poorest country: health care in Malawi



Our current three registrars in Family Medicine: Drs Nitta Chinyama, Modai Mnenula, and Jessie Mbamba.

Waleke Khumalo started to suffer from stomach pains in secondary school, aged 16. A relative working as a laundry attendant at Queen Elizabeth Central Hospital in Blantyre (Malawi's centre of finance and commerce) first took him to the outpatient clinic. Over the next 5 years he went back and forth to the clinic and in that time only once saw a doctor. 'He was a white guy doing endoscopy,' Waleke laughs, 'it was then that I thought to myself, "Where are all the doctors in this country?"'

Waleke's parents passed away when he was in primary school. Encouraged and financially supported by his aunts through primary and secondary school, he did very well, attaining excellent grades, and made a successful application to the Malawi College of Medicine — the first in his family to attend university. The fees for medical school were too much for his family to manage, though, and he resorted to borrowing for the first term, paying it back out of the stipend that medical students receive for food and books. He managed like this for 6 months when Medic to Medic, a UK charity, arrived at the College of Medicine offering student sponsorships. He applied for one and was successful.

THE NEED FOR FAMILY MEDICINE SPECIALISTS

Now in his fourth year Waleke, 26, talks passionately about health care in Malawi and how he believes that putting groups of family medicine specialists into rural hospitals would make all the difference to health outcomes, which are still some of the worst in Africa.^{1,2} Currently, these hospitals may have a supervising doctor (district health officer) but their time is often taken

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up with urgent administrative tasks, such as negotiating with the local petrol station to obtain petrol for the district hospital ambulance. In these circumstances, patients are more commonly seen by clinical officers, a cadre of health workers with 3 years of training after secondary school. Health workers are heavily burdened with their workload and, although many do fantastic work in challenging settings, Waleke has seen clinical errors and delays in treatment. He feels some of these issues could be avoided if there were more trained family medicine specialists on the ground.

He is keen to work in the districts, seeing patients, but help is needed. Currently there are scholarships for postgraduate training in paediatrics and surgery, so doctors prefer to opt for these programmes. These are based at the central hospitals, unlike family medicine in which training is based at the district hospitals. 'Only GPs are willing to go to the districts', he says.

Waleke greatly values the sponsorship he receives from Medic to Medic and would love to have the support of a UK practice as a partner and a mentor going into postgraduate training: 'Communication with a UK practice would stop us thinking "this [situation] is normal"; he says. At the end of our meeting he smiles and is positive: 'I like family medicine because you can be holistic. It is then that you can really understand your patient.'

These sentiments are echoed by Tereza Kathumba, 23, a fifth-year medical student, also funded by Medic to Medic's sponsorship programme: 'Family medicine is broad and it focuses on the person as well as the disease.' She outlined how holistic thinking can make a big difference even when dealing with tropical diseases such as malaria: 'Some people think [the answer to] malaria is just give antimalarials, but if a person is getting it five times a year, you need to think, "What is bringing it on? Do they have a

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mosquito net? What is the drainage like? Is there stagnant water nearby? Do they grow maize near the house? Does everyone in the house have a net? What is malaria like in the community?" If you find out the cause then they will no longer come with recurrent episodes of malaria.'

Like Waleke, it was the lack of doctors in her country that motivated Tereza to study medicine, and she is keen to work in Malawi. The sponsorship from Medic to Medic saved her from using the medical student stipend to pay for her school fees, which often left her with only a slice of bread to eat for the day. She too would prefer to work in the districts, believing that fewer patients would need to be referred to the central hospitals if doctors were evaluating and managing patients in the community.

Could your practice sponsor a family medicine postgraduate trainee and help improve health care in rural Malawi? You could learn more about life as a doctor in Malawi as well as provide valuable mentoring support to some of Malawi's first GPs. Who knows where the partnership could take you?

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With thanks to Waleke Khumalo and Tereza Kathumba. Medic to Medic can be contacted on 0208 869 3603, at info@medictomedic.org, or visit www.medictomedic.org

DOI: 10.3399/bjgp16X685417

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1. World Health Organization. Infant mortality. http://www.who.int/gho/child_health/mortality/neonatal_infant_text/en (accessed 5 May 2016).
2. World Health Organization. Maternal mortality. <http://www.who.int/mediacentre/factsheets/fs348/en> (accessed 5 May 2016).