

# Elective Grant Report



Local kids at Lake Malawi

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The first response I received from most people when I told them I was going to Malawi on elective, was "Where is that?". A small country bordered by Tanzania, Zambia and Mozambique, Malawi is known as 'the Warm Heart of Africa'. I undertook a four week elective in Nkhotakota with the World Medical Fund for Children (WMF), a UK based non-governmental organisation that delivers mobile paediatric clinics and HIV clinics in the Nkhotakota district. This unique experience allowed me to see parts of Malawi that I would never have seen as a tourist and experience the generous and warm culture, but it also opened my eyes to the extent of the poverty in the region and the gut-wrenching reality of children with next to no access to basic healthcare.

One of the smallest nations in Africa, Malawi is dominated by Lake Malawi, which runs down the eastern border of the country, providing a major source of food and income for Malawians. Nkhotakota district runs along the Lake shore and the region is known for its Chambo, a delicious freshwater fish. However, its proximity to the lake means that the region is also known for its high rates of malaria, a disease that affects six million (out of a population of 17 million) Malawians every year, as well as schistosomiasis, a parasitic worm found in fresh water.

Malawi is a peaceful nation and has managed to avoid the conflicts that have troubled its neighbours. Despite this, it is one of the poorest countries in the world, with approximately 67% of the population living in poverty. Its population still relies heavily on low productivity subsistence farming, which leaves them vulnerable to environmental phenomena such as El Niño, droughts and floods. In 2016, the Malawian President declared a 'State of National Disaster' due to a predicted significant shortfall in food, with the UN World Food Program predicting that eight million Malawians would require food aid in 2016. Such food insecurity has led to 50% of the population suffering from stunted growth caused by malnutrition. Additionally, this lifestyle means that many Malawians don't participate fully in the economy, with little ready cash for expenses that they can't grow or produce themselves. The entire country is chronically short of cash, a point that was made clear by the public transport. At the beginning of the month, when the government pays its workers, buses are crammed full, with passengers squeezed wherever they fit. At the end of the month, as cash runs out, buses travel half empty. This meant we planned our trips around the government's pay schedule wherever possible!

*Such poverty means that Malawi's health service is vastly underserved, with just one doctor for every 50,000 people. Although healthcare is free in Malawi, patients are unable to afford transport to the limited number of clinics and hospitals, or food to eat while they are there. Furthermore, it is very common for these facilities to run out of basic medications such as anti-malarial drugs and antibiotics.*

WMF's Malawian clinics are run by a clinical officer, Mr Dezi, with assistance from a nurse, Mary, and locum clinical officers from the government-run District Hospital. To combat the lack of doctors in Malawi, clinical officers are medical practitioners who complete a four year degree, which allows them to practice medicine with a slightly restricted scope of care. Mr Dezi is very experienced in treating the typical conditions found in Malawi, such as malaria, HIV and schistosomiasis, as well as passionate about providing good quality healthcare





Examining patients with local clinical officers



Lining up for medication



The Australian students

to the children of Nkhotakota. During our time in Nkhotakota, he took us to visit some of the HIV positive children who have been sponsored to attend private schools through WMF. His passion for seeing these children achieve to the highest possible standard was inspiring and a real insight into how a relatively small sum can completely transform a child's life.

WMF provides the only healthcare available in the villages it visits. It has a rotating schedule, so it visits each village it services once every month or two. These visits are arranged with a health worker, or the village chief, who communicate the time and date to the surrounding villages. Women, often with their youngest child strapped to their backs and older children walking, walk up to an hour to reach these clinics.

On days when we would head out to local villages, we would load up a four wheel drive with medications from the pharmacy and head down the one highway that runs north to south up the edge of the Lake. We would drive for up to two hours, often down rutted dirt roads and as January is the rainy season in Malawi we got bogged many times! When we arrived in the village, where up to 200 patients were waiting, we would set up wherever there was space available – sometimes this was the church, sometimes the school, or sometimes just on a few chairs under a tree!

*After getting their health passports stamped and registered, each child would be weighed. This was tricky when our step on scales broke, so every child, whether they were 5 or 15 years old, had to hang from the hanging scales! It became clear in my time at WMF that working in Malawi requires ingenuity and flexibility, something the local WMF staff were very good at.*

As a former British colony, many Malawians speak English. They are taught basic English in primary school and all classes in high school are taught in English. Luckily, all the staff at WMF spoke English, as well as the health workers and some of the village chiefs. In addition, the health passports which contain the medical records of each patient are completed in English. However, villagers in these remote regions could not afford to go to high school, and often couldn't regularly attend primary school. As a result, all of our consultations had to occur in Chichewa, the local language.

On my first day, Mr Dezi gave me a crash course in Chichewa and explained that I needed to learn it quickly, or I wouldn't be able to see patients. I learnt enough that I was able to see patients the next day, although there were a few confused looks and bursts of laughter at my pronunciation.

*Unfortunately, learning Chichewa for clinics made me feel like I could speak the language, which I later learned was blatantly untrue. While I could ask people about fever, pain and vomiting, I discovered I couldn't answer basic questions about where I was from or what I was doing in Malawi unless someone translated to English for me!*

After asking a basic history in Chichewa, we would use hand signals to explain to the kids that we wanted to perform an examination. We tried to perform a full exam in each child, at least briefly. As many of these children had not seen a health professional before, they often suffered from undiagnosed conditions such as heart murmurs, massive splenomegaly, chronic otitis media and chronic impetigo.

If indicated, we would then send the children for a malaria rapid diagnostic test if we had them available. In some villages, up to 85% of the children suffered from malaria, as malaria is endemic to the region. Unfortunately, we ran out of these tests two weeks into my placement, so we had to make a clinical judgment on whether the child had malaria or some other condition.

The contrast between my experiences in a major tertiary hospital in Australia, where almost every test under the sun is available, and my time with WMF, where every diagnosis was based purely on clinical signs, was incredible. It required us to go back to basics and consider differential diagnoses carefully. Unlike in Australia, you couldn't send these kids away and ask them to come back if they didn't get better. If you missed a serious diagnosis in these kids they wouldn't see another medical practitioner for two months. This meant that we practised much more cautious medicine than you would in Australia. For example, if a child had flu-like symptoms for more than a few days, they would receive an antibiotic as the risk of misdiagnosis was too great. If the same child attended a GP clinic in Australia, they would be sent home to rest and asked to come back if symptoms persisted or became more severe.

The stories of some of these children were heartrending. One boy attended clinic because of a tropical ulcer on his foot. Such ulcers are easily treated with antibiotics, if the wound is kept clean. Unfortunately, this boy had walked from a nearby village with his mother and did not own a pair of shoes. While we could clean and dress the wound at the clinic, it would be filthy again by the time he got home. This required us to practice realistic medicine. We prescribed some antibiotics and asked his mother to clean the wound each night. While conducting a complete exam, we realised that he was also suffering from malaria and intestinal worms, both of which we treated. Finally, we recognised that he had a heart murmur consistent with rheumatic heart disease, still a common condition in Malawi. Unfortunately all we could do was refer him to the District Hospital for treatment, with the expectation that he was unlikely to attend as the trip would be too much for the family's finances.

In addition to the mobile clinics, WMF ran HIV clinics. In these clinics, we provided free antiretroviral (ARV) treatment to HIV positive kids, as well as generally monitored their health. This is a vital service, as 15% of Malawians suffer from HIV and the Government can't afford to supply treatment for everyone affected.





Long queues to be seen



The mobile pharmacy



Public health education  
by a WMF nurse

MIGA's Medical Support Grant was greatly appreciated by WMF. Mr Dezi mentioned many times how such a generous Grant allowed them to restock their pharmacy with lifesaving drugs. As an organisation with no government funding, WMF frequently runs out of common drugs such as ARVs and anti-malarial medication.

*These lifesaving medications are not expensive, but the quantities required are vast as WMF treats so many patients each week. It was incredible to see how MIGA's Grant was being actively used to treat children without other options and I feel extremely privileged to have played some small part in improving the lives of these kids.*

Despite the fact that I have travelled extensively in developing countries, I still found my time in Malawi both challenging and eye-opening. Malawi is the country that you see featured in World Vision ads for child sponsorship and the footage used in news stories about famine. It is desperately poor, with very limited access to consumer goods, many people still living in thatch and mud brick houses with no sewerage, limited access to fresh water and no electricity. Despite this, the people are friendly and open. The children will yell "Mzungu" as you walk past and are thrilled if you wave back. Everywhere you go, people will come and say "hi" and practice their English with you. In every minivan I caught, strangers would laugh and joke for the entire ride, happily giggling along to a shared joke about the absurdity of life.

I had an incredible time on elective with WMF in Malawi and I would highly recommend the experience to other students. I was able to practice useful medicine, while feeling well supported by the friendly and knowledgeable clinical staff at WMF. I was also able to develop knowledge on conditions rarely seen in Australia, such as HIV, malaria and schistosomiasis. Finally, I was able to experience the friendly, welcoming culture of Malawi, as well as experience some of the natural beauty found in 'the Warm Heart of Africa'.

I would like to thank MIGA for their generous Grant, both to WMF and to assist with the costs of my elective. It was literally life changing for the patients that were treated with the medication it funded and the opportunity to undertake my elective in Malawi is one I will never forget!

**Each year MIGA's Elective Grants Program offers 6 Grants of \$3,500 to medical students undertaking electives in developing communities. Each Grant includes \$2,000 to cover the student's personal elective costs and \$1,500 to provide medicine or other aid to the local community. To be inspired by other past recipients and find out more about applying, visit our website!**

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