A year as a General Medical Officer at Saint Francis Hospital, Zambia

The Beit Trust Junior Doctor Grant Report

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Background

I am a junior doctor from London. I qualified from medical school in 2008. I had been working in the NHS for 4 years when I took an 11-month sabbatical (Out of Programme Experience [OOPE]) to work in rural Zambia at St Francis Hospital. I had completed two foundation years followed by two years of GP Specialty training.

I found out about the hospital in Zambia through the London Deanery for GP Training[1]. They offer three pre-approved OOPE options for GP trainees:
1) Africa Health Placements in Kwa-Zulu Natal, South Africa
2) Watumull Global Hospital & Research Centre in Rajasthan, India
3) St. Francis Hospital in Katete, Zambia
The deanery specifies that an OOPE be taken between ST2 and ST3 to minimize disruption to training. By that stage, trainees have finished hospital-based medicine, and have only one year as a registrar in a GP surgery remaining.

I spoke to a doctor who had recently returned from St Francis Hospital, and it sounded like what I was looking for. My husband (Will) is a professional wildlife photographer. Spending a year living in Africa was something that appealed to both of us. The proximity of St Francis Hospital to South Luangwa National Park helped my husband and I to make our decision. I applied for the OOPE at St Francis Hospital, and was accepted.

The hospital sent me my contract and information about the volunteer allowance of £200 per month. I realized that, although I wanted to fulfill my dream of doctoring in rural Africa, a whole year without a UK salary and with only £200 per month would be very difficult financially. I did some searching online, and managed to find The Beit Trust, and applied for their junior doctor grant.

The Beit Trust grant helped to make Zambia a reality for me. The grant meant that I did not have to worry quite as much about living expenses or other incurred costs, including large outgoings such as malaria prophylaxis and expensive airfares.

[1] http://www.londondeanery.ac.uk/general-practice/during-training/time-out-of-programme-oop
[2] http://www.undp.org/content/zambia/en/home/mdgoverview/overview/mdg6/

Where is St Francis Hospital?

About Katete

Katete is a small town located in the Eastern Province of Zambia. The Eastern Province lacks the commercial agriculture and industry found in other parts of Zambia, and feels significantly less developed than Lusaka, the Copperbelt and Livingstone.

The majority of the people in Eastern Province live a subsistence lifestyle or farm in cooperatives. Most people live rurally in villages without running water or electricity, and very few speak English fluently, but may understand a few words.

About St. Francis Hospital

St Francis Hospital is a large and busy Mission hospital, with 300 beds across 5 wards. It functions as a second-level hospital serving the local population of Katete District (over 200,000 people) and receiving referrals from rural health centres and smaller hospitals the Eastern Province of Zambia (about 1.5 million people) and beyond. Patients will travel to St. Francis Hospital from other provinces in Zambia, and even from Malawi or Mozambique.

The hospital was built is 1947 and has built up a strong reputation over the years, attracting patients and doctors alike.

Working at St. Francis Hospital

The medical department

My role at St Francis Hospital was as a general medical officer working in the medical department at St Francis Hospital. I was primarily based on St. Monica Ward (the female medical ward).

The medical department does not have a consultant, and during my time there, did not have any permanent doctors apart from a junior Zambian doctor who worked in the Outpatient Department and featured on the on-call rota. The previous medical superintendent (who was a paediatrician/physician) left in November 2011, and the current superintendent is an Ophthalmologist. The lack of a permanent senior figure in the medical department means that a great deal of responsibility falls on the relatively inexperienced, short-term, volunteer doctors.

When I arrived at the hospital, I received handover from two doctors from New Zealand who were at a similar stage of their training to me. They had only been there for 3 months. I was the only doctor staying for a year, everyone else during my time there were staying for 6 months or less. Staffing levels can change considerably, and at times I found myself as the only doctor on St. Monica ward looking after 30 – 40 complicated patients alone.

Before going to Zambia, I was under the impression that I would have a clinical supervisor, and that there would be senior support. I did not expect that I would be the most senior member of the medical team (which I was between October – December 2012).

Looking back on my time at the hospital, I have no regrets and would do the whole thing again without any hesitation. However, it was by no means easy, and it requires the ability to smile when faced with difficult circumstances.

Daily routine on the medical wards

Monday to Friday:
Morning ward rounds start at 08:00 by the respective teams on each of the following ward:

- St. Monica Ward (female medical)
- St. Augustine Ward (male medical)
- Mbusa and SCBU (paediatrics)

A full ward round is done daily. Ideally the rounds should be finished before lunch, enabling doctors to get to the Outpatient Department by late morning. However, at busy times, it is not unusual for the round to extend beyond lunchtime.

Evening ward round from 16:30
To see any new admissions from that day, and to see the ICU patients on each ward by the respective ward teams.
The teams normally leave the ward between 18:00 – 18:30.

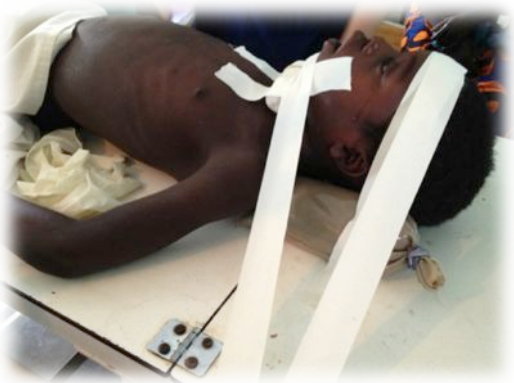
After the ward team leaves the ward, the on-call doctor will be alerted about any new admissions that require attention, or of any other problems.

Meetings
07:30 – 08:00 in the Bishop Oliver Meeting Room
Tuesday – Clinical meeting (departmental teaching)
Wednesday – Clinical Officer teaching sessions (medical team only)
Thursday – Mortality Meetings

Outpatient Department (OPD)

Monday to Friday: General OPD, Ophthalmology, Dental, Sandie Logie (HIV) clinic and Bishop Oliver (Voluntary Counselling and Testing)
Tuesday and Thursday: Gynaecology and Surgical Clinic

General OPD is manned by the medical team and by clinical officers. There are usually a few translators available to assist with consultations. Despite the twice-weekly gynaecology and surgical clinic, many gynaecological and surgical cases (including emergencies) will come through general OPD.



The outpatient rooms are the receiving rooms for emergencies. Patients on stretchers with problems ranging from road traffic accidents to miscarriages will be wheeled in. The rooms have cannulas, fluids, adrenaline and glucose, but are by no means an 'emergency room', and it can be a challenge to respond quickly and appropriately to such cases.

The queues outside the OPD rooms can be extremely daunting. Over 200 people are seen daily across OPD and Sandy Logie (HIV) clinic, which means that by late morning when the doctors arrive at OPD, there are hoards of people waiting to be seen. My approach was to do the best I could do. I took steps to try and reduce unnecessary follow-up appointments, e.g. by advising people with well controlled chronic diseases to get their medicines and follow-up from rural health centres, and by avoiding choosing Monday or Friday as review dates. It is also important to be mindful of how far people have travelled and at what expense to them, and consider whether follow-up is actually in their best interests.

On-call duties for the medical team

The medical on-call covers medicine and paediatrics.

Weekday:
On-call duties begin after the ward teams have left for the day, usually between 18:00 – 18:30, and end at 08:00.

Ward nurses or the coverage nurse will contact the on-call doctor about all new SCBU admissions, and any new admissions on medicine or paediatrics that require attention that evening/night. They will also contact the doctor if there are concerns about the condition of current inpatients.
Because doctors live on site, on-calls are done from home, using mobile telephones. On average, I went into the wards 1 – 2 times during the evening, and had to get out of bed between 1 – 3 times during the night. Some nights, I did not receive any calls, and some nights I received considerably more. Doctors have to work the following day after being on-call overnight.

Weekend:
There are two doctors on-call at the weekend: one to cover Paediatrics during the daytime on both days, and the other to cover adult medicine. One will do the Saturday night on-call, and the other will do Sunday night.
In adult medicine, the on-call doctor will do a weekend ward round and an evening round on both St. Monica and St. Augustine on both days, seeing ITU, the patients that require a weekend review, and any new admissions.
In Paediatrics, the doctor does a full round of SCBU and Mbusa (the Paeds Ward) on both days.
There is no Outpatient Clinic on the weekend, so when the ward round is finished and the jobs are done, the doctor can go home to relax before the evening round. The weekends are busy and tiring.

Medical Specialties

There are no specialists at St. Francis Hospital in the medical department. This means that the doctors have to do everything from renal medicine to dermatology to oncology. It was a steep learning curve, but the St Francis guide, some good reference books and an open mind were helpful. Occasionally, I contacted consultants back in the UK via email for their opinions.

The team at St Francis Hospital

I feel privileged to have been able to work with such wonderful people. Throughout my 11 months at St Francis, there were between 3 – 6 doctors on the medical team at any one time, and we usually had 3 medical licentiates. The various doctors that were there during my time were hard working and inspiring, and we all learnt a lot from each other in difficult circumstances.

There is usually one medical licentiate per ward. Licentiates have received 3 years of training to become independent clinicians. They function in a similar capacity to doctors, but it is advised that in a second-level hospital setting that they work together with a doctor for some supervision. In rural health centres and smaller hospitals, licentiates are often completely autonomous. Such a role does not exist in the UK, and it can take a bit of time to adjust to working with a licentiate. They have a broad awareness of local health problems and are aware of available resources, making them very useful additions to the team. However, they do not have the same depth of knowledge as doctors owing to their shorter training. I found all of the licentiates that I worked with to be excellent. However, as a young female doctor, authority would sometimes pose a problem, and I had to be quite assertive to ensure my instructions were followed if we differed in viewpoints.

I spent a year working on St. Monica, and I got to know my nurses very well. I forged good relationships with them, and found them to be helpful, hard working and conscientious. There were challenges at times getting things done that differed from the norm, such as monitoring urine output or getting daily weights. However, I found that explaining the reasons behind my requests, and persevering cheerfully would go a long way. Difficult staffing levels meant that there often were not enough nurses available, and it was important to understand these limitations and not to get frustrated with the nurses themselves if jobs were not getting done. It was also important to prioritize jobs for the nurses, so that they knew which tasks to do first when faced with limited staff numbers.

Another important group at the hospital are the clinical officers, who are based in General Outpatients. Clinical Officers have received 2 years of training, and are independent clinicians. They see a large number of patients daily and the hospital

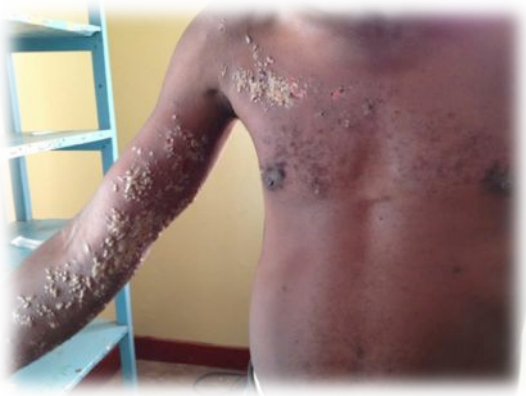
could not function without them. A large number of admissions to the wards will have been seen and admitted by clinical officers. The management plans are usually very good, and the clinical officers have a great deal of local knowledge, however, it is always sensible to review patients on arrival to the ward to ensure their differential diagnoses and management seem appropriate.

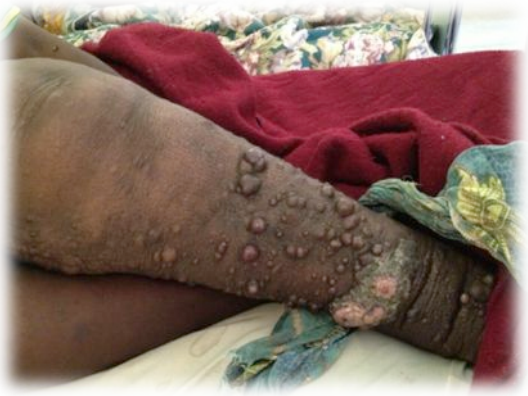
There is a surgical team, an obstetrics and gynaecology team and an ophthalmology team. These teams have consultants (Professor Robert Bleichrodt as the head of surgery, Dr. Makukola as the head of O&G and Dr. Chisi as the head of Ophthalmology). At first, I felt self-conscious at how junior I was when I was asked to give my medical opinion on their patients. However, they were respectful of my medical opinion, and I enjoyed working with them. The medical department is one of the busiest departments in the hospital, and yet it is the only team without a consultant. The other departments do recognize the hard work that we do to keep the department running smoothly without senior guidance or support, but sometimes I felt that a bit more acknowledgement and encouragement from the consultants in other specialties was needed. I also think that as consultants, they should be actively advocating for a medical consultant for St Francis Hospital.

Clinical work

HIV

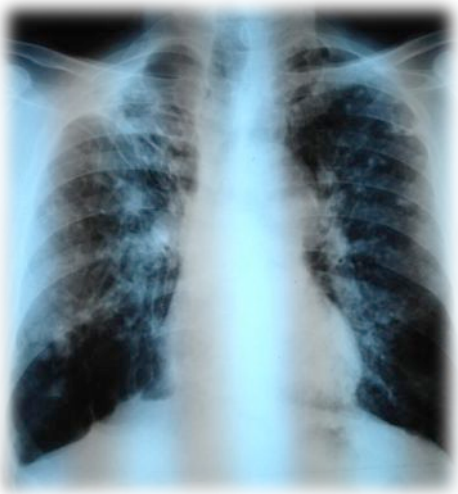
Zambia has a national HIV prevalence rate of 15%[2] (compared to 0.2% in the UK). St. Francis Hospital has the largest caseload of patients on antiretroviral medication (ARVs) in Zambia. There are over 13,000 patients who have their HIV follow-up and management here at St. Francis. This means that a high number of patients seen at St Francis Hospital will have HIV, and many of the ward patients are admitted for HIV/AIDS related problems.
Working on the medical team meant that I quickly became acquainted with HIV/AIDS and the multitude of serious opportunistic infections and complications.

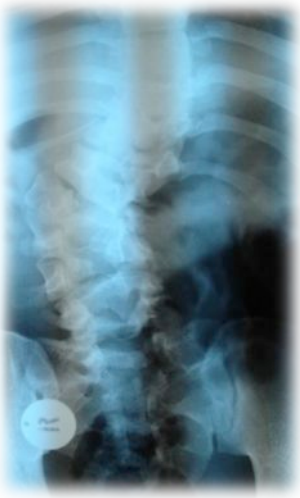




TB

TB is a major health problem in Zambia. 70% of new TB patients are co-infected with HIV. TB is the leading cause of death in patients with HIV.[3]
TB makes up a huge amount of the workload at St Francis Hospital, across all specialties. During my time at St Francis, I saw pulmonary TB, abdominal TB, TB adenitis, TB spine, TB meningitis, disseminated military TB, TB of the spleen, and TB of the adrenal glands.





[2] http://www.undp.org/content/zambia/en/home/mdgoverview/overview/mdg6/
[3] http://www.who.int/mediacentre/factsheets/fs104/en/

Malaria

Malaria in endemic in Zambia, and is a problem all year around. However, the numbers climb during wet season, and it is associated with significant morbidity and mortality (especially in Paediatrics).
As a result of cerebral malaria, I have seen more convulsions during my 11 months in Africa than I had in my whole career to date.

Snakebites

Snakes are seen in and around Katete, and you will see snakebites during your time at St Francis Hospital.
Only one patient died from snakebite during my time at St Francis Hospital, but it was particularly harrowing and I will never forget it. She was bitten on the forehead by a puff adder when she was sleeping on the floor of her hut. She had massive local swelling and bleeding, and died after she obstructed her airway.

Anti-venom can occasionally be sourced, but it is not currently stocked at the hospital, so I had to get pharmacy to phone other hospitals and clinics in the area to source it when needed. I only managed to source it once.
Snakebites tend to be managed initially on the medical wards for supportive measures, limb elevation and monitoring. Necrotic lesions should be referred to the surgeons.

Chronic Disease

Chronic diseases are often referred to as ‘diseases of the rich’, but in recent years have become increasingly common and problematic in developing countries.
Diabetes, hypertension and heart failure make up a huge proportion of work at St Francis Hospital, and they have to be managed with a limited option of drugs and limited investigation modalities.
One of the most important but difficult things I had to adapt to at St Francis Hospital was coping with uncertainty, and being able to accept that sometimes there is nothing that can be done.

Cancer and Palliative Care

In adult medicine, Kaposi Sarcoma and Lymphoma are commonly seen owing to the numbers of patients with HIV/AIDS. In a patient with lymphadenopathy, TB and Lymphoma are the most common differentials (as well as Kaposi Sarcoma and Persistent Generalised Lymphadenopathy of HIV). Fine needle aspirates for cytology can be done on site, or a lymph node biopsy (via the surgeons) can be sent to Holland for histology (allow 2 months for a result). Treatment may need to be started before a confirmed diagnosis is made.

The hospital usually stocks the chemotherapy agents to manage KS, Lymphoma and Breast Cancer. The nurses are not trained or permitted to administer chemotherapy agents, and therefore it falls upon the doctors. I had no experience in preparing chemotherapy drugs beforehand, and I had to read oncology nurse guidance online. We have been passing the skills on how to safely give chemotherapy from one set of doctors to the next.

Another commonly seen malignancy is hepatocellular carcinoma (diagnosis made via history, examination and ultrasound). Unfortunately, we cannot offer any treatment for this, so the management is palliative. It is worth checking Hepatitis B status, and starting Truvada if positive, as it can slow the progression of symptoms. Many other malignancies will be seen at St Francis Hospital, often for palliation.

Breaking bad news is not easy given the language barriers and the low level of education in many patients. If someone had a very low level of education, I took to describing cancer as ‘a sore inside that doesn’t stop growing, and I can’t make it go away with medicine’.

In terms of palliative care, if a patient looked as if they would die in the next few days/weeks and I did not think I could reverse the process, I would offer the family the option to go home. Transporting a dead body back to a village is significantly more costly than taking the patient while still alive. Many families prefer to have loved ones at home to die (also giving the options to try traditional healers as a last attempt). If the patient has weeks/months to live, then I offered symptom control with analgesia (paracetamol, ibuprofen, oral morphine) and other palliative drugs (antiemetics, laxatives), with open follow-up.

Death

The amount of death I saw at St Francis Hospital will stay with me forever. People travel to the hospital from far away, and present late. At times, I wonder if I have become hardened, or even jaded, by the amount of death I have seen. One morning when the ward was particularly full and busy, I had three deaths on the ward in quick succession. None of the deaths were unexpected (the patients had advanced HIV), and the patients were not for resuscitation. They all occurred so quickly after each other. I remember certifying the patients as quickly as possible so that I could

return to my ward round with 30 patients still to see, and I wondered afterwards what an on-looker would have thought about my haste and seeming nonchalance.

Improvisation

At St. Francis Hospital, resources are limited, both in terms of staff and equipment. Drugs frequently go out of stock, as do IV fluids, cannulas, gloves and reagents for the laboratory machines. The weekly Tuesday meeting is when pharmacy and the lab report what is out of stock. The concept of minimum stock levels or an essential drug list (of items that should never be allowed to go out of stock) is broached weekly by the doctors, but remains an uphill struggle.

Improvisation is often needed. Chest drains and paracentesis are done with cannulas and giving sets. IV lines are secured in place with sports strapping. Spacers for inhalers are fashioned out of plastic water bottles. Wheelchairs are made using plastic patio chairs.

There are frustrations, and sometimes people die as a result of the lack of resources, for example, when a drug like insulin or salbutamol does go out of stock.

Management

The lack of seniors in the medical department meant that budgeting meetings, directorate meetings and training meetings all fell under my remit as the longest staying member of the medical team. Also, on a pretty regular basis, I would find myself trying to devise contingency plans because the full blood count machine had broken, or the blood transfusion stocks had been used up.

I had very little prior experience in these areas, but I found myself really enjoying this aspect of the job, and have learnt a great deal as a result.

Life in Katete

On arrival

We were met in Lusaka at the airport, and accommodated at the Zambian Anglican Council guesthouse for 2 nights. Although basic, it was nice to feel welcomed to the country, and I really appreciated it. We were taken to St Francis Hospital in hospital transport.

We were given a 2-bedroom house, which was larger than we were expecting. It had a living room, kitchen, bathroom (no standing shower) and 2 double bedrooms. It also had a large and lovely garden with three mango trees, a vegetable plot and some guava trees.

Unfortunately, the house had not been cleaned for our arrival (although there was fresh linen on the beds); everything was covered in a layer of grime. At that stage, I didn't have any cleaning products, so I went over everything with a rag and a bar of soap!

I also hadn't realized that I would need to buy everything, from kettle to pots and pans and cutlery. So we spent the first week making do without anything, before we managed to go shopping for essential items. As the year went on (and doctors came and went), I acquired more and more belongings. By the end, I had everything I needed. We have set up a system to pass belongings from one doctor to the next.

My husband and I bought a vehicle (4x4 Land Cruiser Prado) to help with his wildlife photography exploits, and to ease everyday life. We bought a car through AutoRec who keep Japanese cars in a bonded stockyard in Lusaka. It was fairly straightforward, but took about 2 weeks longer than expected to get paperwork, number plates and everything else in order. We are so glad that we bought it though, it made life that bit easier, enabling us to go to the supermarket and to escape Katete at the weekend without problems.

I had completed all the paperwork that was required for an employment permit a few months before my move to Zambia. I received a receipt for an employment permit before leaving the UK, and I printed out that document to show at the airport. At the immigration desk at the airport, I was told I shouldn't have entered the country until my employment permit had been received. I was given a report order and was informed that I would need to present before immigration official in

30 days time to get my temporary visa extended. At the time, it all sounded quite worrying. However, as the year went on, my report orders were continually extended, and I never actually received the physical employment permit despite two trips to the immigration office in Lusaka, 6 trips to the immigration office in Katete and a wide-range of 'reasons' for the delay (e.g. we have no card to print the permit on today etc.) By showing our marriage certificate, my husband had no problems as my 'spouse' with immigration officials.

Day to day life

Working in the hospital is tough and tiring. However, day-to-day life in Katete is relatively simple.

There are some challenges that come with living in rural Africa, for example, very frequent power cuts, erratic water supply, creepy-crawlies, snakes, and the nearest supermarket being one hour away by car. But despite these challenges that take a bit of adjusting to, on the whole, life is simpler.

Everybody lives on site. This means that my commute to work consisted of a three-minute walk. It also meant that all my friends in Zambia lived between one to three minutes away from me.

As part of my contract, I was given accommodation and one meal per day, including at the weekends. Doctors tend to have breakfast and lunch at home, and have dinner together in the mess.

I ate lunch at home everyday. Spending an hour at home eating lunch gave me the chance to relax and unwind before returning for the afternoon. Communal dinners in the mess enabled us all to debrief about our day, and to socialize.

The food can get repetitive, and people do tend to grumble about it. However, it was a hot meal that I did not have to cook, and I was grateful for it. Dinner consisted of meat, pasta/potato/rice and vegetable (cabbage or rape) for mains, and a dessert. We received chicken three times a week, with goat or mince on the other days.

Laundry is done three times a week.
Monday – towels and sheets,
Tuesday and Friday – clothes.

In the evenings, we would often go round to each other's houses, or sit around a fire-pit in the garden. There was also a projector that we could borrow from the hospital for movie nights.

There is a guesthouse with a bar/restaurant called Tikondane about 10 minutes walk from the hospital. This is the only place within walking distance, making it easier to decide where to go for a drink in the evenings! It served beer, soft drinks and homemade lemonade. They can also do food, including for large groups, and so we would sometimes call ahead and arrange a buffet style dinner for all of us to give us a break from the mess.

There are also a few options in Katete for drinks/dinner.

For local, seasonal fruit and vegetables and simple groceries, there is the Chada market within 5 minutes walk of the hospital. It is open until 20:00 daily, and this is where I would go to buy onions, tomatoes, flour, bananas, beans and eggs.

Katete stores is 5 minutes away in a car, and is where I would go to buy meat from the butcher, or to buy a wider-range of fruit and vegetables and other groceries. But there aren't many western brands available, and very limited toiletries (no shampoo and no deodorant for example). There are two ATMs in Katete Stores.

In Chipata, one hour away by car, there are two supermarkets (Spar and Shoprite) where you can buy a good range of groceries, including imported brands. There are banks, restaurants, and some hotels in Chipata.

Climate

There are two main seasons in Zambia, the rainy season (November to April) and the dry season (May to October/November). The dry season can be subdivided into the cool dry season (May to August) and the hot dry season (September to October/November).
The cool dry season can be quite chilly, requiring layers and a fleece/jumper in the mornings and evenings. The hot dry season can be unbearably hot, requiring plenty of water to drink and a fan at night. The wet season can be extremely wet, requiring wellington boots to tackle the streams that replace paths on the way into the hospital.

Kit list

Clinical	Useful personal items
Stethoscope	Blu-tack (to hang chitenges on the walls)
Pulse-oximeter	Board Games / Bananagrams
Oxford Handbook Tropical Medicine (can buy on smartphones)	Hand-held blender – for soups and for mango smoothies!
Glucometer (accucheck aviva) and sticks	Bluetooth speakers
Medical calculator for smartphone (body surface area, eGFR etc.)	Co-amoxiclav, flucloxacillin, topical terbinafine (not stocked at SFH)
Splash goggles	Surge protectors
White Coat	Torch (I like rechargeable LED Lensers)
Ophthalmoscope and otoscope	Put movies onto an external hard-drive
Three-way taps	Books/Kindle
BNF and BNFc	
Alcohol hand-gel	
Pen-torch	

Personal wellbeing

Malaria

I would strongly urge doctors to take malaria prophylaxis for their time in Katete. Malaria is rampant, and we did have medical students and doctors who suffered from Malaria during their time in Zambia.

Gastroenteritis

Many medical students and doctors were unwell with diarrhoea and vomiting during my time in Katete. On several occasions, I had to do 'hospital at home' for unwell colleagues and put up IV fluids.
Hand-hygiene is important. The water supply in hospital can be erratic, so at times, you cannot wash your hands. I carried my own supply of hand-gel.
The tap water is from a borehole and is safe to drink.

HIV exposure and post-exposure prophylaxis (PEP)

Working as a doctor at St. Francis Hospital means that you will be doing exposure-prone procedures on patients with HIV and other blood-borne viruses. The risk of HIV transmission following occupational exposure to HIV-infected blood is low (percutaneous exposure: risk 1 in 300, mucocutaneous exposure: risk < 1 in 1000)[4]. If you do sustain a needle-stick injury or mucocutaneous exposure, inform one of the other medical officers in the medical team and follow The SFH Guide guidance.
The hospital has a ready supply of post-exposure prophylaxis ARVs (Truvada[TDF/FTC] / Kaletra[LPV/r]), and we always kept a supply at one of the medical officers houses if PEP needs to be started out of hours (when pharmacy is closed).

Exhaustion

Lunch breaks are important, relaxing on weekends that you are not scheduled to work is necessary, annual leave is essential!

[4] NHS Employers. http://www.nhsemployers.org/Aboutus/Publications/Documents/Needlestick%20injury.pdf

R&R

In & around Katete

Walks

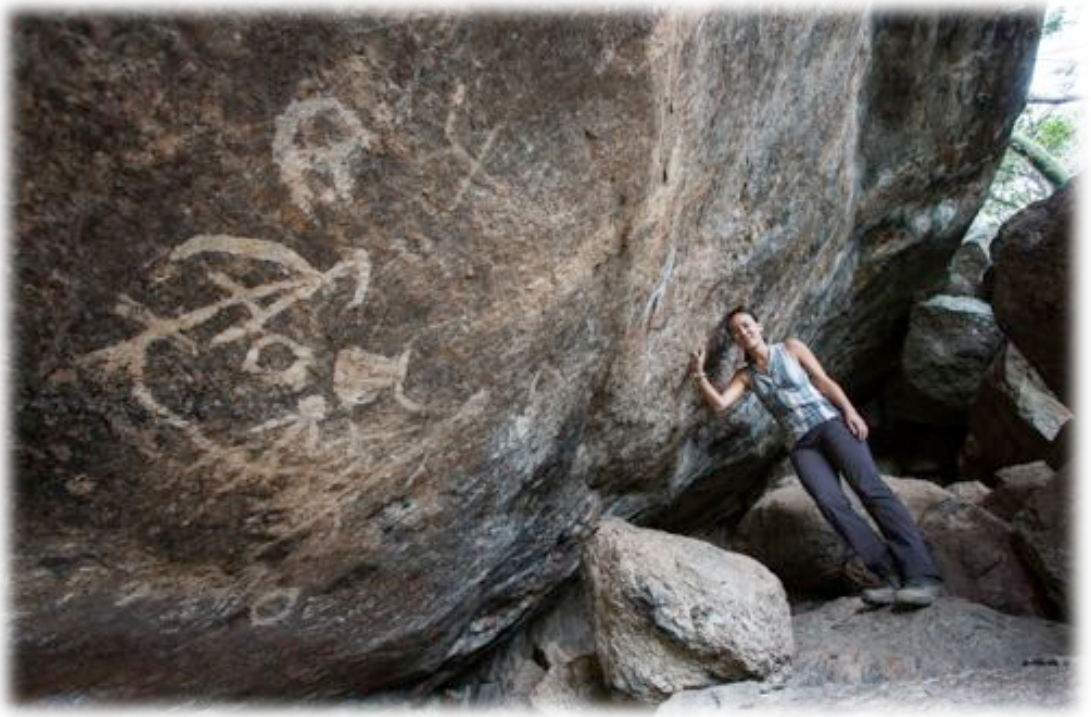
There are a number of nice walks around Katete.
The loop walk goes out into the countryside around the hospital, and ends near to Tikondane Guesthouse. It takes about 1h30 to walk, or 45 minutes to run. In wet season, it becomes impassable due to streams and high grasses.
The Mphangwe Hill walk starts by Mphangwe Girls School and goes along the ridge of the Mphangwe Hills ending at the mobile phone mast end. It offers great views over Katete. It takes about 4 hours, and requires sturdy footwear and plenty of water. We took a picnic lunch, and ate at the top. The walk has to be modified in wet season due to long slippery grass and snakes. To see the view from the top, but not actually do the walking, there is a road up to the mobile phone masts, and we sometimes went up there to watch the sunset, but it requires a 4x4 vehicle.

Chipata

About a one-hour drive from Katete is Chipata. There are hotels, supermarkets, banks, shops, well-stocked pharmacies, and some bars.
Year round (but particularly as the temperature rises in September/October) a very pleasant weekend activity is to visit the Protea hotel for lunch and a swim.
The Protea hotel is expensive for overnight stays, but there are some more reasonable overnight options including Mama Rulas (5 minutes out of town, with a pool), and Deans Guesthouse (on a hill overlooking Chipata).
Blue Gums is an open-air bar behind Shoprite supermarket, and is a pleasant place to go for a night out.

Rock Paintings

The Eastern Province is littered with ancient rock paintings. There are several within 1-2 hours of St Francis Hospital, including Thandwe, on route to Chipata.



Rural Health Centres

I visited several of the rural health centres, assisting the HIV Outreach team by seeing patients during my visits, and I also took the opportunity to visit the villages and surrounding countryside.

Further afield

South Luangwa

South Luangwa is a world famous safari destination, and is located only 3 – 4 hours drive from Katete. My husband spent a lot of time in the National Park for his wildlife photography, and I managed to join him for some long weekends (taking a Friday and a Monday off work). It was wonderful being able to see South Luangwa at different times of the year. It changes a great deal from dry season (dusty and brown but great game viewing) to wet season (lush and green, more challenging to see game, but so beautiful).

Luangwa Bridge

We would sometimes break up the journey from Katete to Lusaka by stopping at Luangwa Bridge, or just go for a relaxing weekend break from Katete. There is a guesthouse called Bridge Camp, with a swimming pool, a nice restaurant, and a lovely view of the river. They can arrange canoe trips and hikes.

Malawi

It takes about 3 hours to drive to Lilongwe from St Francis Hospital.
Lake Malawi is another 3-4 from Lilongwe. The country is small compared to Zambia, and it is easy to travel around.

Livingstone

Victoria Falls is a must-see, but it is quite a long journey from Katete to Livingstone. I also took the opportunity to go across onto the Zimbabwe side of the falls, which I really enjoyed.

Annual leave

The hospital is busy, and staffing levels vary. It is important to take annual leave and to make the most of your weekends in order to prevent feeling burnt out and exhausted.

Memories

I was fortunate to have a photographer with me for my year in Zambia! I'm very glad to have so many photographs and some video footage of my time in Katete. Most of the photographs in this report are courtesy of Will.

I also kept a blog during my time in Zambia, which was a great way to keep friends and family up to date, and served as a nice diary from the year. I recommend WordPress.com if considering a blog.

http://www.DrNat.co.uk

Conclusions

I miss St Francis Hospital already. I will never forget my time there.

It is difficult in 11 months to make a lasting difference, or to implement long-term changes, especially in a department without a consultant or long-term staff. However, the work you put in does make a difference to the patients you treat and the staff you work with. It is important to be pleased with the small achievements that you do make. I managed to implement a heart failure guideline, set up weekly clinical officer teaching, and started a clothes collection (for patients who come in unsuitably dressed or have their clothes cut-off/damaged).

In the week leading up to my departure, one of my patients (a young woman with difficult social issues who I have gotten to know very well over the past 11 months) became tearful when she heard I was leaving. Several other patients held my hands or hugged me, thanking me.

On my final evening in Katete, I held a leaving party at a local venue in town. I invited all the hospital staff. The party was packed with friends and colleagues, and everyone spent the evening telling me not to leave.

It is things like that tell me that I did make a difference, that I did manage to touch people's lives, and that I was appreciated.

Driving away from Katete was hard… but I know that I will go back there someday.

Recommended Reading

Eddlestone M et al. Oxford Handbook of Tropical Medicine, 3rd edition. Oxford: Oxford University Press. 2008.

Parry E et al. Principles of Medicine in Africa, 4th edition. London: Cambridge University Press. 2013. (*There is a copy of the 3rd edition of this book in OPD at St Francis Hospital – it is MUCH too heavy to carry to Zambia, but useful reading beforehand)*

McIntyre C. Bradt Travel Guide Zambia, 5th Edition. Bradt Travel Guides. 2012.

The SFH Guide, 4th Edition.
http://www.saintfrancishospital.net/SFH_Guide_4th_Edition.pdf

World Health Organisation guidelines:
http://www.who.int/publications/guidelines/en/index.html

Useful websites

My blog: http://www.DrNat.co.uk

St. Francis Hospital: http://www.saintfrancishospital.net/index.html

London Deanery for GP Training – Time Out of Programme
http://www.londondeanery.ac.uk/general-practice/during-training/time-out-of-programme-oop

Fit For Travel: http://www.fitfortravel.nhs.uk/home.aspx

NaTHNac: http://www.nathnac.org/travel/

UCLH Travel Clinic:
http://www.uclh.nhs.uk/OurServices/OurHospitals/UCH/htd/Pages/Travelclinic.aspx

The Beit Trust: http://www.beittrust.org.uk/

Burrard-Lucas Photography: http://www.burrard-lucas.com/