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Manguzi South Africa Reflection
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I've always wanted to go to South Africa to experience the history, culture and learn how they are tackling the AIDS epidemic. Hence, when the opportunity presented itself I couldn't pass on it. I had never traveled to Africa let alone crossed the Atlantic. I wasn't sure what to expect since we would be living in a rural area in South Africa. But, I tried my best to prepare in advance by researching and speaking with former students who had been there. As it turns out, as much as I prepared, I still wasn't ready for the eye-opening experiences I've had.

Mangui is in northeast South Africa and located in the KwaZulu-Natal province. With a population of 5,534 it is considered one of the many rural areas in the country. The majority of Manguzi's residents speak Zulu and a few speak Tsonga since Mozambique is only 20 north. A fair amount of people also speak English. Manguzi Hospital is a 304 bed hospital with eight units. This included the following wards: resuscitation unit, male medical, female medical, male surgical, female surgical, pediatrics, maternity ward, multi-drug resistance tuberculosis (MDR) and outpatient clinic). Weekly, a series of medical teams serves thirty mobile points and eleven remote, permanent clinics ranging from 3 to 88 km away. These points were established since numerous patients were far from medical care

and had little to no access to transportation. While there were paved roads in Manguzi, a 4X4 vehicle was required for travelling the back roads to get to some remote clinics.

When I was rotating on the male wards at Manguzi hospital, it became apparent that a significant portion of the population suffered from tuberculosis and HIV/AIDS, surprisingly many patients were co-infected. Many of the patents defaulted on their medications or presented late in the disease process. However, when compliance with medications was not a problem, patients were able to live a fairly similar life to those around them. We, as medical students, have little exposure to HIV in the states. South Africa has the highest rate of HIV/AIDS in the world and approximately 12% of the population or 6 million people have the disease. With it being so prevalent in South Africa, I was exposed to patients with end stage AIDS, AIDS defining illnesses like Kaposi's sarcoma, and many with adverse reactions to their anti-retroviral medication. This gave me a prospective and learning experience that I would have otherwise not been able to have.

The large percentage of the population affected with HIV/AIDS still was influenced by cultural rumors and inaccurate evidence. This still persisted even though South Africa's health sector has initiated many preventative and educational HIV campaigns. Manguzi hospital has been an influential player in promoting education and HIV prevention to help decrease transmission rates. In fact, some of the patients were in denial about the HIV-

positive status, a handful of parents didn't tell their children they were congenially infected, and some preferred to call HIV or AIDS an alternate name cause of the shame associated with the disease.

One of my objectives for this experience was to compare and contrast how labor/delivery was managed and understand the possible challenges unique to women's health in Manguzi. The first appointment of many of the expecting mothers happens well into the first trimester resulting in less accurate due dates. Similar to the US, a series of lab test are completed during this appointment. The number of subsequent appointments following this ranges but the average is four before the baby is born. Typically, the midwives manage labor and deliver uncomplicated mothers while physicians preform instrument-assisted deliveries and cesarean sections. I had the opportunity to scrub and first assist some cesarean sections. One special thing that I became quite fond while the patient was being blocked and the surgery occurring was the singing. Patients, staff and sometimes physicians sang during this time.

While on outpatient clinic, I noticed female patients with vaginal discharge are diagnosed with VDS (vaginal discharge syndrome). These women were then given a cocktail of three antibiotics and a notification card for their partner. I was curious about why these patients weren't tested and given the particular antibiotic that would treat the cause of

their discharge. When I spoke with one of the attendings about this she said it would take a long time to get the results back and by that time the patient may not return to the clinic for treatment. I thought this was resourceful and very practical for a rural area with limited funds.

Unfortunately, there were a handful of domestic violence cases that came to the hospital while I was in Manguzi. Social workers played a large role by talking to the patients and their families but there was little improvement for the patients' situation and often times they returned to the hospital after being abused again. In such a resource limited area there is no women's shelter or safe place other than the hospital for victims of domestic violence.

Seeing how medicine is practiced in South Africa over the course of my month there allowed me to see unique challenges patients and physicians in Manguzi face and appreciate the imperfect American healthcare system. I could not have wished for a better experience for my international elective.