BSG Medical Elective Report

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I undertook a one-month medical elective in Windhoek, Namibia, as part of University of Namibia's (UNAM) international exchange programme via an institutional partnership with Cardiff University. Preparation was largely conducted by email, and our visa was only approved two days before departure. This is a reminder that logistics for global medical electives can be unpredictable and should be planned well in advance. On UNAM's advice, we brought our own PPE (FFP2/FFP3 masks, gowns, gloves, protective footwear, hand sanitiser and scrubs), which proved more affordable and accessible to source in the UK than locally. We also donated the surplus to the hospital at the end of the placement.

Namibia operates a healthcare system offering free public healthcare services to the Namibian citizens depending on circumstance and there is a private sector serving those able to pay. The elective's flexible structure let me rotate across departments. Learning in the hospital ranged from observing admissions being clerked, coordinating referrals, joining multidisciplinary discussions, comprehending the logistics of clinical procedures and operations, and following patients' treatment plans. My experience in the hospitals gave me a rounded view of the healthcare system and service provision, not bounded by a single specialty.

On my first day in the general/internal medicine ward 6B, the gastroenterology patients were managed here rather than in a dedicated unit. I introduced myself to the team and joined the 8am ward round. The ward itself took some adjusting due to narrow corridors, squeaky beds and container-style partition walls dividing rooms of two to four beds, with patients moving freely between them and little sound insulation separating one bay from the next. The doctors and local medical students navigated this with complete familiarity, moving at a pace that meant falling a few steps behind could mean losing them entirely among the beds and dividers. This was not unlike getting lost in the hospital's basement corridors, which looked identical in every direction with no signage to orient you. Despite the compacted wards, their skill in making the most of limited space and resources stood out immediately.

Physical resources were limited but used with real ingenuity. I saw a surgical glove repurposed as a breathing balloon, serving much the same function as an incentive spirometer in chest physiotherapy, improving ventilation, aiding recovery and reducing complications such as atelectasis in immobile or post-operative patients. This kind of low-cost problem solving reframed how I think about "resource-limited". The constraint was equipment, a product of underfunding, not clinical skill or intervention.

Population's demographics, lifestyle and environmental conditions also shape its disease burden directly. Diarrhoeal illness was the tenth leading cause of death nationally in 2021 (mortality up to 22%) with cases frequently coinciding with other infections (urinary tract infections, cellulitis) or an underlying immunocompromising condition (tuberculosis, human-immunodeficiency virus or malaria), which are all endemic to the region. Laboratory turnaround for blood cultures was often too slow to guide antibiotic choice in time, which made clinical history the primary diagnostic tool rather than a supplement to any test results.

This changed how I think when taking a history. Beyond the standard social history, relevant questions here included water and sanitation access, household TB contacts, HIV status within the family and tribal or settlement context based on their address. For example, the semi-nomadic San communities' limited access to clean water contributes to their high rate of diarrhoeal diseases. In a setting like this, social history became a crucial diagnostic tool, rather than background information.

I was also privileged to observe theatre sessions in General Surgery and Plastic Surgery. Common presentations included stabbing or gunshot injuries, pyogenic and amoebic liver abscesses, pseudoaneurysms and severe burns across multiple sites. I assisted in several operations under consultant supervision, while remaining conscious of my limits. As someone unfamiliar with the local healthcare system, I made sure my involvement stayed within an appropriate scope of practice and ethical boundaries of a medical student.

Namibian communities have a well-documented history of resilience, shaped by German colonisation, the Herero and Nama genocide, and apartheid-era policy under South Africa. In a hospital context of their individual resilience, this can be translated into patients' delayed presentation to the hospital. Patients avoided hospital admissions and altogether any attendance until symptoms became severe, commonly citing lost income from missed work and long journeys to hospital. I witnessed this starkly in a patient presenting with grade 4 hepatic encephalopathy as a first presentation of undiagnosed hepatitis B and chronic liver failure. This neurological manifestation was broad enough to encompass a wide range of differentials, including drug-induced psychosis. Diagnosing and assessing the patient on first presentation was therefore challenging, which the team navigated competently.

Poverty shaped outcomes in other ways too. For instance, malaria remains fatal largely where anti-malarial treatment is financially inaccessible. Children and pregnant women are at greatest risk of its complications, such as cerebral malaria, renal failure, multi-organ failure. Liver abscesses and hepatitis A/E were strongly linked to food hygiene. Kapana, a popular street or market food, was repeatedly flagged by doctors as a transmission risk in crowded, under-sanitised market conditions. This prompted a push for community hygiene education, run by medical students and local NGOs.

Under-resourcing showed up operationally as much as clinically. A shortage of pathology request forms could mean a doctor walking a seven-storey building to find a ward with spare stock before a blood sample could be taken. A small inefficiency compounds across a shift and this can contribute to staff burnout. Discharge was another bottleneck, patients from outside Windhoek without their own transport relied on a single weekly bus. This results in a low bed turnover and a constrained hospital capacity.

One encounter stays close to my heart. A patient admitted with severe encephalopathy, who few expected to survive, described his recovery as being "revived". He attributed this miracle to the dedication and humanity of all hospital staff involved in his care rather than the actual treatment itself. In response to his recovery, he committed to giving up recreational drugs, tobacco and alcohol. Watching him through withdrawal and recovering from his illness, his biggest obstacle wasn't the physical symptoms but the anxiety surrounding the environment he'd return to. A different environment and a supportive community seemed fundamental to sustaining his decision. I was struck and amazed to see how compassion can change a patient's life immensely.

I'm grateful to the doctors who taught me throughout the elective, including Dr Dmytro Kravchenko (General Surgery), Dr Kaveto Andreas Sikuvi (Emergency Medicine) and Dr Alberto Arevalo (Plastic Surgery). I'm equally grateful to the local medical students at UNAM, who we got to

know through university lectures and workshops. Alongside their own workload, they kindly acted as guides, translators, cooks and everyday teachers in the hospital. Their generosity and hospitality, given how little time they had to spare, said a lot about their culture in the hospital and the country. And finally, a huge thanks to my friends Anest and Becky, who shared this journey with me that became a lifelong cherished memory.

This elective gave me more than a clinical experience abroad. It sharpened my ability as a historian and reinforced how much a comprehensive history, not just a test result can shape diagnosis and treatment. It showed me how far clinical resourcefulness can stretch limited equipment. After this experience, I would like to carry forward the principle when learning in a different healthcare system: to look at what it has, not what it lacks. I return with a stronger interest in global health and a clearer sense of compassion to see patients holistically. There will be real admiration for the doctors and students in Namibia whose adaptiveness and resilience made this such a formative and enjoyable month.

Emergency Simulation Workshop in UNAM's medical campus, taught by Dr Kaveto Andreas Sikuvi

In front of UNAM Hage Geingob Campus and the hospital with Becky Warland and Anest Edwards

Completed a 10km race in Swakopmund and fundraised a total of £950 for Hope Village Namibia and Ebenezer Soup Kitchen

Golden hours at Dune 45, Sossusvlei during our weekend trip in Namibia

Theatre experience with Mr. Kravchenko in General Surgery Department

Post-lecture with the Namibian Medical Students

Farewell dinner with Namibian medical students

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