AMECA and LAST

MALAWI – Mwanza and Dedza

Friday 15th April to Sunday 1st May 2016

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Introduction

Our previous visit to Malawi in 2014 consisted of a week in a district hospital, Mwanza, followed by a week in the University hospital at Blantyre. It was decided that for this visit the overall format would change with both weeks being spent at district hospitals. Also it was felt that revisiting a hospital would be useful as there would already be contacts and an understanding of the working practices in that particular hospital. Our visit involved a week at Mwanza District Hospital, which we had visited in 2014, followed by a week at Dedza District Hospital. The purpose of the visit was similar to previously, the prime purpose being to teach the clinical officers open mesh inguinal hernia repair. However this wasn't exclusive and other teaching opportunities were used in clinics and on ward rounds. Also Alison undertook nursing teaching on the wards in both hospitals. There were opportunities to meet other members of the group, David and Catharina Hunter, to discuss their experiences in Mulanje and Thyolo. We met with Prof Eric Borgstein which was useful as he gave feedback about the project from his perspective.

Mwanza District Hospital – Sunday 17th April to Thursday 21st April

Mwanza is a town in the south west of Malawi less than 5 km from the border with Mozambique. The population served by the hospital is approximately 250,000, who mostly come from Malawi, but about 100,000 live in Mozambique. At present there is civil unrest in the neighbouring parts of Mozambique. There is a refugee camp nearby with a large UNHCR and MSF presence.

The journey from Blantyre to Mwanza takes under two hours (110km) via a good sealed road. There were three police / military checkpoints that were passed through without difficulty. Mwanza District Hospital is beyond the main market area in town, visible from the road, a short distance down a side turning on the right. Mwanza Hotel is about half a kilometre further on along the main road to the border also on the right. The hotel facilities were considerably improved over the last two years, presumably as a result of the presence of so many NGOs. The accommodation is adequate (MK 20,000 a night, approximately £20). Our refurbished room had air conditioning that worked and a television that didn't. No

mosquito net was provided but we had fortunately bought our own. The television was useful as a mounting point for the mosquito net.

Dr Raphael Piringu was still the District Health Officer (DHO) but unfortunately he was unwell with malaria and we met with him only on our last day. The District Medical Officer (DMO) was Luke Chimera, who had been a clinical officer at the time of our previous visit. The Senior Clinical Officer was Andy Chitsulo, who hadn't been at Mwanza two years ago and was hoping to start on the BSc Surgical programme in Blantyre later this year.

Daily Routine – The morning handover was at 0730. It was attended by the medical and nursing staff. In the absence of the DHO it was led by various clinical officers. On Wednesday there was a Grand Round instead of the usual handover in the meeting room. This didn't seem particularly useful as the large group of nurses and medics moved from one ward to the next and on each ward the report was given in a small office inaudible to most in the group.

After the handover we would visit the surgical wards followed usually by theatre. Availability of basic equipment was the main restriction for operating capacity.

Wards – There were no major changes in the wards following our previous visit. Observations were done intermittently. Consent for surgery was basic and the surgical sites were not marked. The surgical patients were seen and examined in the treatment rooms on the wards prior to surgery.

Outpatients – There was a busy outpatients department where the patients were effectively triaged. We attended the outpatient clinic on Monday afternoon. The consultations were brief with basic histories taken. The plan was recorded in the patient passport.

There was an interesting mix of pathology in the surgical clinic. There were many different types of hernia, some of which I felt were inappropriate to be repaired at Mwanza. These included a very large umbilical hernia in a young adult and a midline laparostomy hernia. There were two patients, one with an abdominal mass that was the size of a full term uterus and another with a thigh mass of unknown aetiology, that I suggested referring to Blantyre for imaging rather than proceeding directly to surgery.

One of the patients in the surgical clinic had 4 months previously had viral warts excised but the wounds had failed to heal with simple dressings and were progressing. She had extensive labial ulceration and was HIV positive. She was referred to Blantyre for biopsy.

We attended an HIV Clinic on Wednesday morning after the operating list finished early. This was run by the Senior Clinician in the hospital. The main health issues remain malaria and HIV.

Surgery - The operating theatres had not changed significantly in two years. The scrub sinks were now plumbed in and diathermy was available. There was a single bulb in the theatre light compared to three bulbs two years ago.

A list of procedures performed at Mwanza is given below. The Senior Clinical Officer (SCO), who had an interest in paediatric surgery, and the other Clinical Officers (COs) shared the operations and I was first assistant for all procedures. The COs required variable amounts of assistance, some being unable to perform hand ties. There would be benefit in a basic Surgical Skills Course or similar being made available to the COs early in their training.

Date	Surgeon	1st Assistant	Operation
19.04.16	AC	TL	Ing hernia. 5yr (Male)
19.04.16	CO	TL	Inguino scrotal hernia.
19.04.16	CO	TL	Ing hernia. Open mesh repair (Male)
20.04.16	AC	TL	Neck lipoma (LA)
21.04.16	AC	TL	Child herniotomy
21.04.16	CO	TL	Child herniotomy
21.04.16	CO	TL	Epigastric hernia. Adult
21.04.16	AC	TL	Chin abscess. Child

Presentation - I gave a two hour presentation on trauma on one afternoon to the Clinical officers. I outlined the format of an ATLS course and then gave a presentation on how to manage major trauma. The level of care described in the talk could not be delivered in Mwanza but would be deliverable in Blantyre provided the patient could reach the hospital promptly.

We had dinner with Andy Chitsulo on our last evening in Mwanza. We discussed how the project could be improved and he agreed to fill in the questionnaire that we have subsequently sent to him. Before we drove back to Blantyre on the Thursday afternoon we met with the DHO in his office and then had a meeting in the Mwanza Hotel with a nurse working with MSF in the refugee camp. The medical facilities in the camp were basic and the refugees were generating additional work for the already stretched Mwanza hospital.

Dedza District Hospital – Monday 25th April to Friday 29th April

Dedza is the highest town in Malawi at 1590m and is about three and a half hours drive north of Blantyre. It lies very close to Malawi's western border with Mozambique. During our time at Dedza we stayed at the Dedza Pottery Lodge. The lodge is 5km from the hospital. The accommodation is in a block of six rooms behind the pottery with views across open countryside. The shower and mosquito nets were good and the television worked intermittently. The restaurant was better than Mwanza Hotel and this was all reflected in the room rate of MK48,709 a night (approximately £50). The Lodge restaurant is famous for the cheese cake which we duly sampled. It was more a cheesey cake than a cheesecake, with lashings of cream and jam but very pleasant and rather filling.

On arrival at Dedza District Hospital we met with Dr Solomon Djere the DHO. The surgeon, Mike Chisema, was also acting as the DMO. The hospital was newer than Mwanza but had similar difficulties with supplies and equipment.

Daily Routine – There was a daily handover at 0730 attended by the medical and nursing staff. This was well led by Mike Chisema who encouraged discussion from a slightly reluctant audience. On the Thursday morning there was a Powerpoint presentation on neonatal hypothermia following a recent case.

Wards – The wards were similar to Mwanza. The male and female wards had a mixture of medical and surgical patients. In theory there were 36 beds but extra patients were accommodated if required on mattresses on the floor. Ward lighting was poor with no mosquito netting over the beds or on the windows. There was no bed linen or bed rests to enable frail and ill patients to sit up.

Infection control measures were challenging. There was often no water or soap to wash hands and nothing to dry hands. Gloves and aprons would be worn by the nursing staff attending patients but these were not changed as nurses moved from patient to patient, probably for cost reasons. Nurses would wear face masks when caring for potentially infected patients, for example TB, but the masks worn were ineffective for the task.

Outpatients – An ad hoc surgical clinic was arranged for the Monday afternoon on arrival in the old TB ward. There were four beds in a large room with no bed linen or electricity. The patients waited outside the ward in the corridor and were called in two at a time. The clinic finished at 17.45 by which time it was already almost dark. The last few patients were examined under the light of mobile 'phones.

We saw a wide range of surgical problems. There remains an unmet need for prostate surgery and surgeons who can perform retropubic prostatectomy. Hernias and scrotal swellings in children and adults were common but there was also a smattering of other cases.

Surgery – The plan was for 3 days of surgery but it all depended on the number of emergencies. There was one main theatre and a second minor theatre. On one day there was only a single anaesthetist available which further restricted activity. Equipment issues were similar to Mwanza. There was no diathermy or defibrillator in theatres but there was a wider range of surgical instruments than in Mwanza. The drapes were of a similar quality with multiple holes.

Date	Surgeon	1st Assistant	Operation
26.04.16	CO	TL	Exc lipoma L arm
26.04.16	CO	TL	Exc lipoma neck
26.04.16	TL	CO	LIH Repair
26.04.16	TL	CO	LIH Repair
26.04.16	TL	CO	Epigastric Hernia (mesh)
27.04.16	TL	CO	LIH Repair
27.04.16	TL	CO	LIH Repair
27.04.16	CO	TL	Lipoma
27.04.16	TL	CO	Hydrocele repair
28.04.16	TL	CO	Umbilical hernia repair (Child)
28.04.16	TL	CO	RIH Repair (Child)
28.04.16	CO	TL	Exc ganglion
28.04.16	TL	CO	RIH Repair (Child)
28.04.16	TL	CO	LIH Repair (Child)

The lists ran as possible when the theatres were not busy with emergencies. There was a steady stream of caesarian sections and on the Thursday the start was delayed by a below knee amputation for trauma. As most of the major amputations were done for trauma in Malawi the procedure was performed by the orthopaedic team while I watched quietly in the background. A conventional long posterior flap amputation was performed without a tourniquet. The patient had lost considerable blood prior to surgery and was transfused with blood pre-operatively from one of the nursing staff.

In Dedza the COs took turns at assisting with the mesh hernia repairs despite strong encouragement to be the operating surgeon. Looking through the log books in both hospitals more than 90% of the procedures performed were caesarean sections or other related obstetric procedures.

General Comments on Nursing Practice – The trained and student nurses all wore bright, clean uniforms that were a stark contrast to the wards and patients. The DHO at Mwanza was most enthusiastic about the budget having been made available for nurse's uniforms.

The personal care for patients was generally administered by a relative rather than a nurse. Washing facilities for patients were lacking. There was a shortage of drugs with no governance of nursing practices. Emotional support for patients was ad hoc and the patients did not seem to expect what would be regarded as dignified care in the UK.

These comments largely reflect the low level of funding for health care in a developing country. Despite the circumstances the nurses are keen to learn. Following a teaching session at both hospitals early in the week there was considerable improvement in observing, recording and acting appropriately upon clinical signs. Sample observation charts will be sent to both hospitals to hopefully maintain this improvement. A further area for development in the nurses training would be encouragement for them to teach patients and their family members about wound care and personal care.

General Comments on Surgical Practice – The meeting with Prof Borgstein at the end of our visit was useful. Our visits are to help teach and nudge towards an improvement in the care the clinical staff can provide, particularly hernia repair. It is important that we work with the local medical community in training the doctors and clinical officers to work better within the roles that they have.

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