AMECA and LAST

MALAWI – Mwanza and Blantyre

Friday 16th May to Sunday 1st June 2014

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Introduction

The two week visit was arranged by LAST and AMECA. Broadly the visit was planned as a week at a District Hospital (Mwanza) followed by a week at Queen Elizabeth Hospital in Blantyre. Although the visit to Queen's was shortened to a couple of days there were opportunities to meet other members of the group and discuss their experiences in Mulanje and Nsanje. May was chosen as a good time to visit Malawi as the rains had finished and the daily temperatures were very reasonable.

Mwanza – Sunday 18th May to Saturday 24th May

Mwanza is a town in the south west of Malawi about 15 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. The state healthcare system is free at the point of delivery in Malawi and the health system in Malawi is better developed than that in neighbouring Mozambique. There is no reimbursement system for treating patients from Mozambique.

The journey from Limbe 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 visible from the main road, a short distance down a side turning on the right.

Accommodation for the week was in the Hotel Mwanza. Hotel Mwanza is less than a kilometre from the hospital, further along the main road towards Mozambique. The hotel was built about 30 years ago but is now undergoing refurbishment. The staff are helpful, particularly the manager Patrick Banda. A reasonable breakfast is included in the room rate (40 US $) and there is a bar / restaurant for evening meals (chicken, chips and a beer for two for 4,500MK, approx. £7). Electricity and plumbing generally worked but the mosquito net had several holes of the size of mesh for a hernia repair.

We met with the District Hospital Officer (DHO), Dr Raphael Piringu on the Monday morning. He gratefully accepted the surgical equipment that we had bought with us and then we were shown around the hospital by one of the three Clinical Officers in Surgery (COS). During the week we met with Rapheal every day. He was most enthusiastic about pushing to improve the service at Mwanza.

Daily Routine – The morning handover attended by medical and senior nursing staff was at 07.30 every day with presentations by the medical staff at the Friday handover. The DHO was present for the handover and the meeting concluded with prayers. A ward round took place after handover of the surgical patients before heading to theatre for the all day operating lists. The theatres stopped for lunch for about an hour and a half. At the end of the day, usually about 17.00, there was a brief evening round to review the post-operative patients. During the day we would see referrals as requested.

Wards – There were male and female surgical wards. The wards were divided by low walls into six bedded bays. There were no curtains to partition the wards. If necessary patients would sleep on extra mattresses placed on the floor.

Patient observations were taken intermittently. We encouraged the taking of routine observations and note keeping. The operation site was not routinely marked pre-operatively. Although the importance of this was explained it was noted that there were no marker pens. There was considerable scope for future nursing training although this would require careful planning because of the interaction with COs.

The children's ward had a dedicated bay for burns. This is a big problem particularly during the cooler months. We later visited the Burns Unit at Blantyre and although there seems to be a protocol for transfer this is not always adhered to for several reasons.

The Maternity Unit was very busy. In the one block were ante and post natal areas, delivery room with four bays and a warm room with 2 cots as a special care baby unit. There was also a four bedded room for mothers and babies where the babies were placed if the neede a slight increase in level of care (Kangaroo).

Outpatients – There was a large, busy outpatients department where the patients were effectively triaged. The surgical patients were also seen and examined in a treatment room on the ward.

Support Services – The Pharmacy and Central Stores are was combined. There were the expected difficulties with obtaining and paying for supplies.

The Radiology Department had a basic Xray machine for plain imaging and an old ultrasound machine. The department was run by two radiographers. There were no radiologists. The xrays were taken onto old fashioned films. The ultrasound machine was of such poor quality that its value must be questionable in the spectrum of the general surgery that they experience. All reports that I saw read "large spleen, homogenous liver, no free fluid".

Surgery - No surgery was scheduled for the Monday, which in conjunction with the election on the Tuesday, resulted in there being only three days of operating. The experience of the COSs was variable. In Mwanza none of the three COSs had performed inguinal hernia repairs but had assisted at several Bassini repairs. Thus I demonstrated six open mesh repairs on five patients with 4 different COs assisting, the three surgical and one other. The three surgical COSs then each performed two mesh repairs with me assisting. Table 1 lists the operations that I was scrubbed in for during these three days.

Date	Surgeon	1st Assistant	Operation
21.05.14	TL	K	Ing hernia. Open mesh repair (Male)
21.05.14	TL	M	Ing hernia. Open mesh repair (Male)
21.05.14	TL	L	Ing hernia. Open mesh repair (Male)
21.05.14	TL	X	Ing hernia. Open mesh repair (Female)
21.05.14	TL	M	Bilat rec Ing hernia. Open mesh (F)
22.05.14	M	TL	Ing hernia. Open mesh repair (Male)
22.05.14	K	TL	Ing hernia. Open mesh repair (Male)
22.05.14	L	TL	R hydrocele repair
22.05.14	L	TL	Ing hernia. Open mesh repair (Male)
22.05.14	M	TL	Epigastric hernia repair. No mesh (F)
22.05.14	K	TL	Drainage scrotal abscess
22.05.14	TL	K	Small bowel evisceration (Male)
23.05.14	M	TL	Ing hernia. Open mesh repair (Male)
23.05.14	L	TL	Ing hernia. Open mesh repair (Male)
23.05.14	K	TL	Ing hernia. Open mesh repair (Male)

Surgical Clinical Officers – Michelle, Ken and Luke.

The trained surgeon at Mwanza was away for the week that I was present. I was called in on two evenings to see emergency patients. One was a typhoid perforation that was transferred to Queen's, the other an abdominal stab wound with evisceration that was treated locally.

The theatres were largely as expected. There were no power failures during operations. The theatre light had three out of five light bulbs working. The diathermy worked and used a reusable plate. The selection of surgical instruments varied from case to case but was usually adequate apart from the scissors that often did not work. The suture material and mesh we had bought with us.

The limited number of gowns allowed for a surgeon and one assistant but no scrub nurses. The drapes often had a large number of holes. Operation activity was limited by availability of sterile equipment rather than surgeons or patients.

Queen Elizabeth Hospital – Monday 26th and Tuesday 27th May

On Monday morning we met with two of the consultant paediatric surgeons for a ward round. The range of pathology was very impressive. There were three children with large intra-abdominal tumours probably Wilm's. Other cases included Hirschsprungs, burns and genital malformation.

In the afternoon TML gave a tutorial to the surgical trainees on trauma. There were three trainees present all of whom were relatively junior.

On the Tuesday we went to the ITU and the Burns Unit to see patients that we had transferred from Mwanza the previous week. In the afternoon Peter Willson gave a tutorial to the surgical trainees on diathermy.

One of the paediatric surgeons, Mr Bip Nandi, was a young, enthusiastic surgeon who had trained in the UK. He was most helpful and an excellent point of contact for discussion about the best way to take forward the programme.

Points for Discussion

Overall a very enjoyable and enlightening visit for us that we would like to repeat. There are a number of points for discussion.

1. Feedback from Mwanza and Queen's about how they perceived the visit.
2. Format of future visits. Consider longer period in District Hospital (DH), do we go to the same hospital or move around, if longer period in DH do we go to two different hospital?
3. Timing of future visits
4. Nursing training and COS training.
5. Interaction with COST Africa Programme.
6. Achieving changes in practice.
7. Distance learning.

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