

Student Elective Grant

REPORT

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Destination: **Lilongwe, Malawi**

Birth of a Dream: A student's journey to the warm heart of Africa

Simply say the word 'Africa' and the clichés come thick and fast. For some, it's images of safari, desert sunsets and sweet faced children. For others it's the gaunt bodies of poverty, the protruding pot-belly of a malnourished child or a stricken mother clutching her dying infant. It is little surprise then that in the small, land locked country of Malawi in South East Africa you can experience both. Sometimes referred to as the "Warm Heart of Africa", Malawi is better known for its world class fresh water diving and Madonna's adopted Malawian child than it is for the devastating 2005 famine or the critical state of its health care system. 14 million people crowd the slender shaped nation making Malawi one of the most densely populated countries in the world. Increasingly burdened by poverty and disease, 40% live below the poverty line and at least 15% live with HIV/AIDS.



Above: Bwaila Hospital

Africa was always on my radar as a place to experience a different realm of medicine so I took the opportunity to do a 6 week elective in Obstetrics & Gynaecology in Malawi's capital, Lilongwe.

The O&G department is divided between two locations, Kamuzu Central Hospital and Bwaila Maternity Hospital. Kamuzu is a one thousand bed tertiary care hospital which housed most specialties from ophthalmology to

paediatrics and intensive care. Lack of funding was evident by the run down and filthy condition of the wards, absence of running water and severe



Above: Laura giving antiretrovirals to a baby.

overcrowding where patients slept on mattresses between the beds and on the balcony outside. Despite this the physical structure and conditions were comparably better than at Bwaila.

Bwaila Hospital was where I spent most of my time. It provides obstetric care free of charge so we served the poorest of the poor there. Up to 40 deliveries were performed each day in a small, open plan 15 bed



Above: Newborn babies at Bwaila.

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labour ward where privacy was non-existent. The water drainage and sewage systems did not work creating disastrous hygienic implications and an odour not for the faint hearted. The grossly under funded, under resourced and hopelessly understaffed hospital was overwhelmed by huge patient numbers and many complicated deliveries. In stark contrast there were only 2 to 3 deliveries a day on the paying maternity ward at Kamuzu Central.

With just 9 weeks of previous obstetrics experience I was thrown head first into assessing emergency presentations and post operative patients, delivering babies unassisted, performing episiotomies, attempting ultrasounds, managing eclampsia and post partum haemorrhage, performing manual vacuum abortions and suturing vaginal tears. There was little time for teaching and the old saying, 'See one, do one, teach one' had never felt so real. I was out of my depth and at times overwhelmed by the vast number of patients. This notoriously overburdened maternity ward delivers a staggering 12,000 to 13,000 infants every year so an extra pair of hands, as inexperienced as they were, proved to be invaluable. It wasn't long before I knew how to say 'push', 'breath', 'pain?' and 'sorry' in the national language, Chichewa. The majority of the doctors were overseas trained and the African 'brain drain' was certainly evident, leaving midwives and midwifery students to bear the majority of the workload. Despite our best efforts we were often pushed to capacity and unable to provide an acceptable standard of care so that women were delivering unattended and on the floor.



Above: Labouring women waiting on the floor.

I saw young fistula patients who had lost every ounce of dignity, cases of rape and domestic violence, ectopic pregnancies and incomplete miscarriages. HIV rates in pregnant women near 20% so treating exposed infants

with antiretrovirals was a daily occurrence. Infertility secondary to pelvic inflammatory disease was particularly devastating as a woman's worth is measured by her ability to bear a child. Advanced cases of cervical cancer were frequent as there was no screening program let alone radiotherapy or chemotherapy. Unbelievably, we even had a case of siamese twins!



Above: Bwaila Labour Ward

For both hospitals, equipment and supplies were an ongoing source of despair. Equipment such as vaginal specula and a light source to properly examine a patient were too few, inadequate, broken or not present at all. Of the two ultrasound machines available, one worked. Theatre supplies and surgical sets were often incomplete so that caesarean sections were completed with a scalpel blade held directly in the surgeon's hand putting themselves at serious risk of exposure to HIV. Sterile conditions were a myth. Suction machines did not work making bloody abdominal procedures like caesareans an almost blind procedure. Consumables such as needles and syringes frequently ran out so that episiotomies were performed without local anaesthetic. Scissors in the delivery packs to cut the cord or carry out an episiotomy where either not present or so blunt that the patients suffered considerably while an episiotomy was being chewed. I quickly learnt to use old fashioned foetoscopes as foetal dopplers did not exist to monitor babies' heart rates. The disarray in which many of the delivery beds were in was appalling, with holes up to 15cm in the frame from rust. The laboratory was so overwhelmed that we sometimes could not get a full blood count. There was only one functioning incubator and oxygen concentrator.

Failed breech deliveries and shoulder dystocia were common as were traumatic vacuum deliveries because there was only one theatre for emergency caesarean sections. In the meantime, many babies died waiting for theatre. Most women presented late in labour due to lack of transport and isolation so that foetal distress, birth asphyxia and intrauterine deaths were all too

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common. Each day we had one baby die, sometimes up to four. Being required to help with the resuscitation of many newborns was particularly difficult to deal with. Too many mothers died during or shortly after their 5th, 6th or 10th delivery from post partum haemorrhage because the blood bank was empty. The notion that obstetrics is a happier medical specialty was certainly challenged when I found out 1,800 per 100,000 women in Malawi die giving birth.

The conditions at both hospitals were nothing short of heart breaking and created many unsafe and frustrating scenarios. I was fully exposed to the burden of poverty, lack of education and powerlessness that so greatly impacts on their health.

When I reflect on my time in Malawi it is easy to dwell on the many challenging moments and confronting scenes that are part of developing world health. However, there were so many great experiences and times of happiness as well as a sense of hope that things will improve. The many successful deliveries and good outcomes were extremely uplifting and satisfying considering the extraordinary circumstances. My favourite delivery was by head torch one evening when the power went out! It is a credit to the hospital and the staff that so many women do receive quality health care.

On weekends I took the chance to visit the striking Lake Malawi as well as safari in Liwonde National Park. We tucked into local cuisine of nsima (boiled maize flour and water) and chicken...nsima and rice...nsima and beans, although I wasn't game to try a local delicacy, mice on a stick. I grew to love Malawi and quickly discovered that it was a country of beautiful people and places. It was an unforgettable time and a privilege to be a part of.

I would like to extend my gratitude to MIGA for awarding this Elective Grant to such a worthy hospital, which will be gratefully received by the department through the

Chitenje Maternity Trust. The Medical Support Grant will be used to purchase much needed equipment for the new Bwaila Maternity Hospital building and is a step towards achieving equitable care for birthing mothers in Malawi.



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