Basingstoke Hoima Partnership for Health (BHPH) – 2010 Update

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Fig 1. From Riga to Hoima

I was part of a 19 strong team who visited Uganda (fig 1) from 7th-18th October, 2010. For ten it was their first visit to Hoima and of those six had never experienced the challenges of Africa before.

The group could be divided into four by speciality:

Maternity Team (fig 2)


Fig 2. Maternity team

Dr Amara Sohail, Consultant, Basingstoke
Dr Rob Bates, Consultant, Basingstoke
Ms Hatty Ivey, Midwife, Basingstoke
Mrs Rhi Grindle, Midwife, Basingstoke
Mrs Jackie Perry-Smith, Midwife, Basingstoke
Dr Natalja Kalashnikova, Consultant from Riga, Latvia

Paediatric Team (fig 3)


Fig 3. The paediatric team

Mrs Claire Hunter, Paediatric Nurse, Basingstoke
Ms Anne Reilly, Paediatric Nurse, Basingstoke
Dr Greg Boden, Consultant neonatologist, Reading and Oxford
Dr Rhiannon Furr, SpR, Oxford
Dr Adrian Humphry, SpR, Oxford

Anaesthetic Team (fig 4)


Fig 4. The anaesthetic team at Murchison Falls

Dr Keith Thomson, Consultant, Basingstoke
Dr Emma Taylor, SpR, Portsmouth
Dr Elizabeth Read, SpR, Salisbury
Dr Nick Jones, Consultant, Basingstoke

Others

Dr Richard (retired physician) and Mrs Jane Waldram (retired nurse),
Mrs Teresa Bates, practice nurse, Basingstoke,
Duncan Sherlock, trip organiser, who runs the Azur private maternity clinic, the Mustard Seed orphanage and the Duhaga Boys' School in Hoima.

Richard and Jane (fig 5) had recently been working in Siberia but had also visited Kissisi Hospital in Uganda several times since 2003.


Fig 5, The faces of experience

Richard's vital team role was to investigate existing management structures and suggest how Dr Francis, the new medical director, could implement new and hopefully more effective systems at HRRH (Hoima Regional Referral Hospital).

Rob and a team had been out in July setting in place the structures needed for caesarean sections to be performed at the Azur Clinic.

They organised equipment, job descriptions and training of staff including local surgeon Dr Milton.


Fig 6. Caesarean at Azur

The current team were very impressed at how well the set up at Azur was running. Fig 6 shows a caesarean section being performed by the local Ugandan staff under spinal anaesthesia.

Future plans for Azur include a paediatric ward, for which Duncan says the £30K required has been pledged but running costs will be in the order of £5K per year.

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The road to Hoima

From Entebbe airport with a quick stop for breakfast at the Gateley Hotel the journey took more than four hours in the two minibuses owned by the 'God is Able' company (fig 7).

Fig 7. Team minbus

The roads were good but the elderly vehicles had no seat belts and I could not help thinking about the article 'Letter from Uganda' in the June 2010 edition of *Anaesthesia News* which describes a terrible accident resulting in the death, because of no available trauma care, of several members of the anaesthetic department at Mulago Hospital who were en route to the funeral of a colleague. But there were interesting sights on the way like a herd of cattle blocking the road (fig 8) and a motor bike carrying a bed (fig 9), at least the driver was wearing a helmet, sadly a rare occurrence in most African countries.


Fig 8. Longhorn cattle blocking the road


Fig 9. Bed on a bike

Accommodation at the Crown Hotel

This was conveniently placed within walking distance of the Hospital. Our trip literally started with a bang on the first evening when an explosive bolt of lightning struck the swimming pool only about eight metres behind some of the team who were enjoying a chilled Nile Special beer at the adjacent bar. This was followed during the night by several palpable earth tremors. The rooms were comfortable but the same evening meal of rice, fried fish, chicken, beans and peas did begin to pall somewhat after a week. There were repeated power failures and a surge protector was an essential piece of equipment when charging up phones and computers etc. Only ten miles from the hotel oil has been discovered, local rumour has it that a battalion of troops are guarding the oil field and that the President's family have bought most of the land. Only time will tell whether this discovery will improve life for the people of Hoima or not.

Maternity at HOIMA

Where should one begin? Perhaps the dilapidated hospital sign (fig 10) was indicative of the need for improvements.

Fig 10. Hospital sign

There are still far too few staff, both midwifery and doctors (two SHOs and one consultant). HRRH has only ten trained midwives but Basingstoke has 110, both having around 3,000 deliveries per year.


Fig 11. Labour ward at Hoima

It must be easy for the overworked staff, both midwives and doctors to become emotionally blunted by the exhaustion of coping with continuous and unrelenting stream of pregnant women (fig 11) with a variety of conditions ranging from normal labour to life threatening haemorrhage, uterine rupture, eclampsia, obstructed labour and severe infection. The majority of cases performed in the one functioning operating room were related to obstetrics, in fact the hospital did not at present have a general surgeon on staff. In the past month 86 caesareans had been performed according to the record book.


Fig 12. Challenging caesarean at Hoima

Our team performed seven caesareans (fig 12) and other operations, including saving the life of a thirty-two-year old woman who suffered a severe PPH after delivering 29 weeks premature twins. She was taken to theatre and under general anaesthetic had a Foley catheter inserted into the uterus and blown up to 60 ml with saline. We had (optimistically) requested four units of blood for her but remarkably six were supplied. She was given three plus a syntocinon infusion and recovered well.

Cleanliness in the Maternity unit was an issue which needs to be addressed. The post natal infection rate was far too high and on the labour ward the only functioning basin, situated in an office, had a damaged tap which could only be turned on and off using the nearby curtain. Privacy was also an issue as Rob discovered when suturing a third degree tear on the ward, he asked for more light so the staff just pushed the bed nearer to an open window!

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The three midwives in our team between them assisted at several births (fig 13) including a set of twins (named Jackie and Natalia after their deliverers).

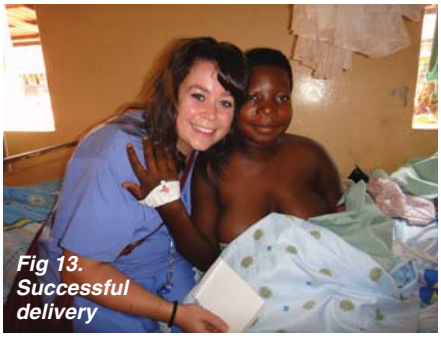

Fig 13. Successful delivery

Anaesthesia

The locally available drugs consisted only of ether, thiopentone, ketamine, pethidine, diclofenac, atropine and suxamethonium. (no non depolarising muscle relaxants were available).

Fig 14. Slick spinal

1.5% heavy lignocaine was used for spinals (fig 14) but the only vasopressor available was adrenaline 1 in 1000 diluted to 10 ml and given in 0.5 ml boluses. Consultant anaesthetist Dr Stella was delighted with the 30 amps of ephedrine and 25 spinal needles we gave her (fig 15). The various cupboards seemed to be full of 'stuff ' that would never be used again. On our final day Nick and other members of the team helped clean up and reorganise the disposable equipment like tubes, masks, IV cannulae and syringes. The latter were designed for only a single use and one had to remember not to expel the air as that rendered it useless. The team tried out a new portable Glostavent anaesthesia machine made by Diamedica (fig 16).

Fig 15. Anaesthetist Dr Estella

Fig 16. Portable Glostavent

This consisted of a heavy duty suitcase which contained the three main components, a reservoir bag, a vaporizer and inspiratory/expiratory circuits. The vaporizer could use either isoflurane or halothane and the set up was very simple. The team used it for four cases; three caesareans and the post partum haemorrhage. A very useful feature was the spinning device in the exhaust tube just beyond the expiratory valve which indicated expiration, this was particularly useful when the patient was breathing spontaneously. The draw over machine entrained room air which could be supplemented with oxygen via an oxygen concentrator or directly from a cylinder.

The only problem with an otherwise excellent piece of equipment was the filling and emptying of the vaporizer. The filler screw cap should be fixed to the vaporizer with a chain and the filler funnel needs to be of a better design. It would be preferable to have a tight fit with some tubing connected to the bottle of inhalational agent. It required two people to fill the vaporizer, one to hold the funnel and tilt the suitcase so the hole was vertical and the other to pour in the isoflurane (fig 17).

Fig 17. Filling the vaporiser

Emptying the vaporizer also required two people and had to be performed outside the theatre, preferably out of doors because of spillage. We also discovered that the vaporizer leaked all over the inside of the case, if it was stored flat and full, but did not leak when only a third full. It could prove an excellent machine for the travelling anaesthetist especially if one could also have compartments for syringes, drugs and monitors built into the lid.

The Paediatric Team

This consisted of a consultant neonatologist, two registrars and two paediatric nurses. They spent their time resuscitating babies in theatre (fig18) and also doing what they could to help on the overcrowded children's ward.

Fig 18. Neonatal resuscitation

Members of the team also spent time at Azur training the staff in neonatal resuscitation techniques.

The Mustard Seed Orphanage / local church

The former was run by Duncan Sherlock (fig 19) and was fun to visit. The fitter members of our group played a couple of closely contested

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Fig 19. Duncan at the Mustard Seed orphanage

football matches against the senior pupils (fig 20).


Fig 20. Football teams

On the first Sunday I attended a service at the nearby Anglican church. Some of my favourite hymns were sung including Amazing Grace composed by former slave ship Captain, John Newton. It seemed particularly poignant in Africa. There were two collections and then at the end of the service an auction of fruit and vegetables by individuals who could not afford to give money, apparently sometimes chickens were brought to church for this purpose. What a brilliant custom, perhaps it would work well in churches back in the UK? Christian culture was also promoted in some of the street signs (figs 21, 22).

Fig 21.

Fig 22.

The Conference

This three day event at the Kolping Hotel in Hoima, kindly sponsored by the UNFPA, consisted of three separate days (see programme on www.africansmiles.co.uk under UGANDA). Day One was Maternity, Day two Neonatal Paediatrics and Day three was on peri-operative care organised by the anaesthetic team.


Fig 23. Conference day 2

Over sixty people attended each of the three days (fig 23), the audience asked many questions, feedback forms suggested they thought it was worthwhile. On one occasion Dr Amara raised the issue that perhaps more information could be provided for women concerning symptoms of pre-eclampsia and the fact that they ought to go to a medical facility for testing. I suggested that a good way to help would be to provide blood pressure machines and dip sticks for protein measurement to TBAs (traditional birth attendants) in the community. Sixty five percent of all deliveries in Uganda take place out of hospital. This suggestion caused an uproar because the general perception among the medical community is that TBAs are just witches and should be eliminated! Apparently four months ago a TBA tried to perform a caesarean section on a woman at home. The baby died but the woman remarkably was brought to hospital alive and survived.

The conference was also attended by four charming student nurses from Denmark (fig 24) who were spending three months on an OOPE (out of programme experience) working at HRRH. They seemed particularly enthusiastic about my talk on 'Airway adventures in Africa' which was really a promotional talk for the work of the Mercy Ships (www.mercyships.org.uk).


Fig 24. Danish student nurses

The girls all seemed keen to go and work on board the *Africa Mercy* sometime in the future. One of them told me that when a friend from Copenhagen visited her recently bringing copies of the latest fashion magazines she quickly lost interest when she thought about the school children nearby who did not even have shoes to wear. Another of them told me her horror at seeing a nurse on the paediatric ward picking up an IV cannula she had dropped on the dirty floor and attempt to reinsert it in a small child's arm with the comment 'in Africa we do things differently.'

R and R

After a week in Hoima we travelled to the spectacular Paraa Safari Lodge for a two day rest. The food, especially the salads and the puddings, was a welcome change from what we had experienced all week at the Crown in Hoima. Magnificent rooms opened out onto a short patio to a large swimming pool (fig 25) which included an adjacent bar with underwater seats.


Fig 25. Veranda opening to pool

The first afternoon we went on a boat trip up the river Nile to Murchison Falls which was

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discovered in 1852 and named after the then president of the Royal Geographical Society.


Fig 26. Nile crocodile


Fig 27. Goliath crane

We saw hippos, crocodiles (fig 26) and many bird species (fig 27) on the upstream journey and then we trekked up a steep and windy path with spectacular and dramatic views to the top of the falls (fig 28).


Fig 28. Murchison Falls

We then returned to Paraa Lodge by road with a brief stop for a drink at the Red Hot Chilli Bar. The following day we did an early morning and a late afternoon game drive. Our smiling ranger was called Taban (we nicknamed him Taliban), he was delighted to allow Natalja whose surname was Kalashnikova hold his AK 47 rifle (fig 29).

In the morning the most spectacular sight was a large school of hippos, probably more than 500 in a bay. I spent time trying to get a photo of one with its mouth wide open for my Airway Adventures in Africa talk (fig 30).


Fig 29. aka AK


Fig 30. Airway Adventures


Fig 31. What is in the tree?

The highlight of the afternoon was a small dot in a distant dead tree, (fig 31) spotted by hawk-eye Adrian, which materialised into a leopard when viewed through binoculars (fig 32).


Fig 32. A leopard

The lions eluded us but we saw many Ugandan Kob (fig 33),


Fig 33. Ugandan Kob

Jackson Hartebeeste, Oribi, Buffalo and Giraffe (fig 34), some of which were only a few feet away.


Fig 34. Giraffe

On our final day the eight hour journey to Entebbe was delayed for three hours because the ferry needed to transport us across the river ran out of diesel (fig 35).


Fig 35. Ferry cross the Nile

Our drivers, Haruna and Stephen, did a brilliant job over very difficult bumpy muddy roads and eventually delivered us safely to the Boma Hotel situated a few minutes' drive from the airport.

While we were at Paraa Rob and Richard had a positive three hour meeting with Dr Francis and the other senior management team at Hoima to discuss ongoing support for HRRH by BHPH. This has been facilitated by a £26K grant over two years from DFID which can be used to help finance various projects and also assist with travelling costs and accommodation for volunteers in this and future teams.

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In Conclusion

I feel much more optimistic than last year about the future of the link between Basingstoke and HRRH. Progress has been made, there is a new nursing school which has just received accreditation and there are plans to build much needed additional accommodation for medical staff. I think there is a general feeling that BHPH ought to send out at least four multi-disciplinary teams in 2011 with additional projects like diabetic care.

We hope that our suggestions, regular contact by email and phone and ongoing support will empower Dr Francis in his difficult task of trying to remove some of the entrenched practices and introduce new more modern and up to date management structures. BHPH plans to be involved for the long term in an effort to help provide the people of Hoima District with a more modern heath care structure which perhaps in the future might even become an example for the rest of the country.

Most of the team travelled back home the day after the homecoming of Ugandan hero middle distance runner Kipsiro (fig 36) who won the gold medal in both the 5000 and 10000 metres at the Commonwealth Games in Delhi.

Fig 36.

Nick stayed on at Paraa for a few more days while Rhi and Hattie worked in an orphanage in Kampala.

They all met back at Entebbe for a day's fishing on Lake Victoria where Hattie caught a Nile perch of at least 60lb – what a monster! (fig 37).


Fig 37.
What a monster!

Comments by team members

1. Paediatric nurse Claire:
Uganda was truly one of the best experiences of my life and I can't thank you enough for making it possible for me to be part of it. I find it hard to put into words just how amazing it was and worry that self-ishly I may have got more from the experience than I was able to give. However, you all assured me that the first trip is often more about discovering Africa/Uganda and appreciating how others live and developing relationships with them and I feel that I was definitely able to do this and thoroughly enjoyed doing so. With regards to Hoima hospital I can see many areas where improve-ment could be made but I was also incredibly impressed and motivated by the skills and care the (paediatric) nurses and doctors gave with such limited equipment and resources. They were all very warm and welcoming and I just hope we left them with some ideas and encouragement that they can use in practice.

2. Latvian Obstetrician Natalja:
Africa is far away, but never was so close. I experience deep sympathy and profound compassion towards those people, and wonder about their patience. This trip made my personal world more rich.


Fig 38. Hoima first timers + old hand Rhi

3. Paediatric nurse Anne:
My first trip to Africa was an amazing experience and one that far outweighed my expectations. I was expecting it to be an emotional rollercoaster, but in fact the fun and laughter outweighed the heart-wrenching moments. The Ugandan people were warm and welcoming and it was a humbling experience to see how simply they lived and appreciated all that they have. I went out not really knowing what I would be doing or how I could be of use, but with an open mind to make the most of the experience and see what evolved. Whilst we saw some very sick and malnour-ished children in the hospital, the contrast in seeing the vibrancy and fullness of life the children in the orphanage had, helped to keep things in perspective and they always made us giggle. Although we didn't have enough time to make a real difference, we have come back with ideas that we are keen to move forward with and now feel compelled to go back and continue what we've started.

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