BHPH team to UGANDA 10-22 October 2011

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Introduction

This was the fourth multidisciplinary group from Basingstoke to visit Hoima Regional referral Hospital (HRRH) in 2011. The team worked for 8 days with a two day break in the middle to visit Murchison Falls Safari Park. The focus consisted of both clinical work, particularly in the understaffed maternity and paediatric units, and also training of qualified staff and students.

The group (fig1): This was divided into 5 teams.

Fig 1. The team

1. Obstetric : Amara Sohail, Bhavna Mangal
2. Anaesthetic : Keith Thomson, Sarah Davidson, Ian Davis
3. Paediatric : Rhiannon Furr, Ann Riley, Samantha Osborne
4. Midwives : Rhiannon Grindle, Harriet Ivey, Anna Halliwell
5. Others : Duncan Sherlock (trip organiser), Rebecca Thomson (audit), Rob Jacobs (painting and decorating).

The group increased four days later by the arrival of Vanessa Rippon (paed SpR), Dai Cox (administrator), Iain Mckenzie (vet), and Edward Hurley (account manager)

Day 1

The team arrived safely at the Crown Hotel in Hoima after a four hour drive in minibuses from the Boma Hotel in Entebbe. That afternoon Keith and Rhi G met the acting medical director of HRRH Dr Simon – to obtain permission to work alongside local medical staff, both in a clinical and training capacity. Dr Estella Kisembo, the local consultant anaesthetist, was delighted to see us as during the next two weeks there would be a VVF camp with five visiting surgeons, accompanied by additional nurses but no anaesthetists. This extra clinical workload put pressure on the poorly staffed local department of anaesthesia which consisted of Dr Estella and two anaesthetic officers, Edward and Eunice. A third, Caroline, was on maternity leave and a 4th, who only did night shifts but according to the obstetricians often did not appear even for an emergency.

After an 'all too familiar supper of fried food at the Crown Hotel,' some of us watched an excellent film called 'The Proposal' while others played a riotous card game called 'mafia.' This latter became increasingly popular as the visit progressed!

The Basingstoke Anaesthetic Team

This consisted of one consultant and two CT2s (fig 2).

Fig 2. Anaesthetic team & Dr Estella

During eight days at Hoima members of the team were involved in 20 cases, 18 of which were caesarean sections.

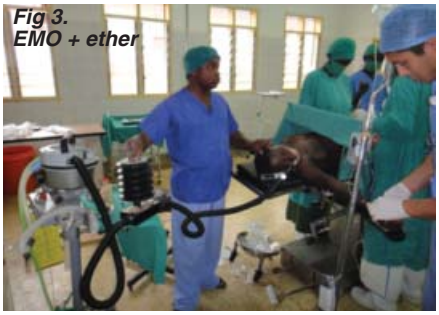

Fig 3. EMO + ether

Three were given a GA using ether for maintenance (fig 3) and the remainder were under spinal anaesthesia using 5% heavy lignocaine. Sadly it was not possible to resuscitate eight of the babies who were delivered by caesarean. This was due to women presenting too late at the hospital with their uterus either rupturing or ruptured after spending many hours in labour at home. One woman had travelled about 60 miles on a motor bike after being rejected by two other health facilities. Interestingly out of 15 cases carried out under spinal anaesthesia, using 5% heavy lignocaine, ephedrine was only used on one occasion. Limited monitoring in theatre and the recovery area was supplemented by two 'Life Box' pulse oximeters (fig 4) brought by a team member.

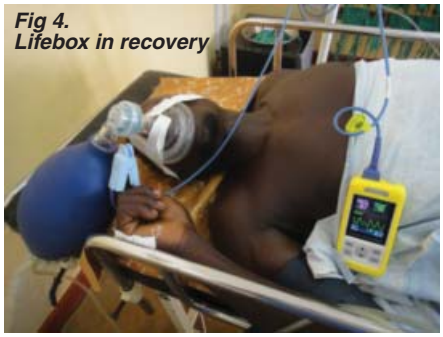

Fig 4. Lifebox in recovery

Normally no-one except relatives monitored patients in the recovery area adjacent to the maternity theatre and post-operative pain relief was minimal. The usual practice was to give an intra-muscular injection of diclofenac 75mg before the patient came off the table. But on several occasions team members provided effective post-operative pain relief on the ward by giving 5mg IV doses of

ketamine. This worked particularly well in the case of one young woman who had a chest infection post C/S under GA for a diagnosis of twins which turned out to be one baby + a huge ovarian cyst. After ketamine she was able to remain sitting up and thus able to breath much more effectively (fig 5).


Fig 5. After post-op ketamine

One woman whose spinal block was beginning to wear off before delivery was given 25mg of ketamine which helped but when the baby was born she kept saying 'God forgive me for I am a sinner!'

We discovered that no caesareans had been carried out at the Azur private clinic for several weeks because the anaesthetists at Hoima, who were paid/case to go there, did not go because the hospital had run out of heavy lignocaine and the EMO machine was malfunctioning. The Basingstoke team did provide spinal anaesthesia for two caesareans at Azur with members of the team travelling by 'boda' with no helmets (fig 6).


Fig 6. No helmets

I also assisted at the delivery of a breech presentation of an abnormal dead foetus with a large head (fig 7).


Fig 7. Breech delivery at Azur

Small doses of ketamine and diazepam provided adequate sedation, analgesia and relaxation for the procedure to be safely accomplished. Another interesting clinical scenario was a woman for caesarean section on magnesium sulphate because of an eclamptic fit. Even though there were no clotting studies available it was felt that spinal anaesthesia was the safest technique because of the risks of hypertensive surge on intubation, magnesium sulphate potentiating non-depolarising muscle relaxants and unrecognised fitting under GA. Much to everyone's surprise the baby cried soon after birth. In three GA cases members of the team tried out a video laryngoscope (Aircraft Medical) which provided an excellent view for intubation. A patient was also anaesthetised for repair of a strangulated inguinal hernia using a portable Glostavent machine.


Fig 8. Multiuse cleaning fluid packet

Dr Sarah converted a scarce packet of cleaning fluid into multiuse by inserting a Venflon (fig 8).

The VVF Camp

This was run by an organisation called Engender Health which was sponsored by USAID. The team initially screened 203 patients suitable for surgery. During two weeks they operated on 92 of those, 87 of which were dry after their operation – an excellent result. They plan to return in February to do the remaining cases. Dr Amara's husband, Dr Sohail, a consultant urologist, was helpful with certain of the VVF cases, particularly when the abdomen had to be opened. Three cases were operated on simultaneously, two in the main theatre (fig 9) and one in a small adjacent room.


Fig 9. VVF surgery

Spinal anaesthesia was used for all of them, the team brought a supply of 0.5% heavy Marcain for this purpose and also 2.5 litres of fluid/patient. This was the first VVF camp where all surgeons were Ugandans.

I was impressed with this worthwhile initiative and attended as a guest the very moving closing ceremony at the end of the second week. There were various speeches; but particularly poignant was one of the patients who knelt down on the ground in front of the organisers and thanked them for the changes that the surgery would make in her life (fig 10).


Fig 10. VVF patient thanking her surgeon

While I was accompanying the group of VIPs being shown round the recovery wards, we passed a partially screened off dead body wrapped in cloth by the path outside the Maternity unit. We had been shown the very abnormal chest X-ray of this young woman the day before which probably showed severe pulmonary oedema but most likely other pathology as well. Sadly she had passed away during the night. Later on her husband removed the body now also wrapped inside some matting, on the pillion of his motorbike (fig 11) to take her back home for burial.


Fig 11. Dead wife on a bike

A picture taken the day before in the post natal ward shows another woman on a bed with a box beside her containing her dead baby (fig 12). Sadly life in many African maternity hospitals is fragile.


Fig 12.
Dead baby in box

R and R – Safari

The team spent two days at Murchison Falls Safari Park. The first afternoon, after watching the Wales v France rugby World cup semi-final, there was a trip up the Nile dodging hippos and crocodiles followed by a walk up beside the


Fig 13.
Guide Taban at Murchison Falls

spectacular Falls (fig 13) to the top where Rebecca's boyfriend Iain took the opportunity to propose (fig 14).


Fig 14.
The proposal

We were then driven back to Paraa Lodge Hotel passing en route a herd of 'muddy' buffaloes (fig 15).


Fig 15.
Muddy buffalo

The following day we went on safari and were lucky to see both a leopard in a tree (fig 16) and also a lioness with four cubs (fig 17) as well as


Fig 16.
Leopard in a tree


Fig 17.
Lion cub

passing many antelopes and giraffes (fig 18) and driving into the middle of


Fig 18.
Giraffe

a herd of elephants (fig 19).


Fig 19.
Elephant

Two of the party who went on safari early the next morning were rewarded by seeing another two leopards and two male lions, one of which was stalking 'lunch'. The four hour drive back to Hoima was made more challenging by a serious amount of rain.

The second week

This involved more clinical work and also some formal teaching. One afternoon the midwives (fig 20), paediatric and anaesthetic teams spent two hours at the Hoima School of Nursing running a series of workshops for 150 student nurses.


Fig 20.
Midwifery workshop

Sarah and Ian ran a modified ALERT course for 45 minutes (fig 21) and then repeated the same presentation three more times.


Fig 21.
Dr Sarah teaching

They suggested to the students that they ought to become involved with monitoring of patients on the wards and they discussed the measurement of blood pressure, heart rate and respiratory rate and what values should indicate that a call for help was required. We had observed students on placement in both Hoima and Azur just hanging around watching, not really getting involved in anything. The feedback from the managers of the school of nursing was good and I feel that subsequent BHPH teams ought to spend time teaching and doing workshops for this group of students who will be the future of nursing and midwifery care in Hoima and other parts of the country. The anaesthetic team also ran a morning Lifebox course for three of the anaesthetic officers, Edward, Eunice and Caroline. Their knowledge was good and the advanced course was used rather than the more basic. Edward had already attended a course run by members of the Association of Anaesthetists in Mbarara in May.

Rebecca and Rob collected data from 100 maternity cases looking at the use of partograms and drug charts. Rob with some assistance from Ed and Dai did an excellent job painting all four delivery rooms in the maternity unit (figs 22, 23). Specialist horse vetinerary surgeon Iain assisted at two caesareans. Apparently under British law vets


Fig 22.
Paintng and


Fig 23.
Decorating

are allowed to treat humans during nuclear warfare!

Thad Cox and little Charity

One morning the team were invited to local missionary Thad's house for a pancake breakfast.


Fig 24.
Thad and Dr Iain

This charming American (fig 24) worked for the diocese of Hoima. He had been the successful manager of a catering company back in the USA until a suicidal attempt with a pistol put an end to his employment. He came to Uganda about 10 years ago and was involved in various projects including helping fund medications for poor patients at HRRH. In his sitting rooms was a copy of a prize winning image (fig 25) taken during a famine in Southern Sudan on March 1st 1993 by Kevin Carter who subsequently committed suicide about six months later soon after receiving his award.


Fig 25.
Prize-winning photo

The photo shows a heart-breaking scene of a vulture stalking an emaciated child collapsed on the ground while struggling to get to a food centre.

One of Thad's protégées was 9-year -old Charity (fig 26) who had had


Fig 26.
Nine year old
Charity

an ileostomy performed (fig 27)


Fig 27.
Ileostomy

because of a presumed typhoid perforation about 6 months previously at HRRH which now needed reversing. Since then she had been languishing in the Azur Clinic while a suitable surgeon is found to perform the surgery.

Sports day at the Orphanage

This was organised by Rhi G. Members of the group participated with the children at the Mustard Seed Orphanage in a fun filled afternoon (figs 28, 29).


Fig 28.
Sports day at the orphanage

The latest arrival to this very well run orphanage was a small abandoned baby who had been found in a small plastic bag being used for playing catch by a group of children down by the river.


Fig 29.
Sports day at the orphanage

Horror stories from Africa never cease to surprise me.

Our last day

The team were driven back to Entebbe via the craft market in Kampala, where we spent time negotiating for and purchasing various items. The last afternoon and night were spent at the excellent Boma Hotel only a short distance from Entebbe airport. There we were reunited with six of the group who had survived the grade 5 white water rafting on the Nile at Jinja (figs 30, 31).


Fig 30.
White water raft on the Nile


Fig 31.
Did we stay in the raft?

Final comments

From my own perspective I had continued with two of my agenda items in Africa. Firstly to provide medical education and secondly to introduce more young medical professionals to the day by day realities of working in Africa. In our group we had two anaesthetists, one obstetrician, one midwife and one paediatric nurse who were on their first visit to Uganda. Being a pessimist it is difficult to see the medical care available in many parts of the continent changing much

within the next generation, but I feel it is important to encourage ones younger colleagues both doctors, nurses and others, to work there. They are unlikely to change 'the system' but will learn much and undoubtedly will have the privilege of helping to save the lives of a few people they come across in the vast and challenging continent which is Africa.

PS

Just before Christmas we received an exciting email from Thad saying that he had received the best Christmas present possible: the return of a now healthy Charity after successful surgery at Mulago Hospital in Kampala (figs 32,33).

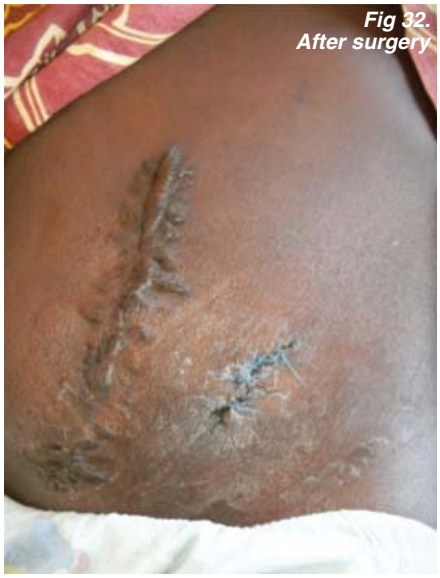

Fig 32.
After surgery

Fig 33.
Charity is happy