

**The Department of Obstetrics & Gynaecology at
Kamuzu Central Hospital and Bottom Hospital,
Lilongwe, Malawi**

A Situation Analysis

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Tarek Meguid, MD, MPhil, DTM&H
Obstetrician & Gynaecologist

Elled Mwenyekonde, DCM
Clinical Officer, O&G

It is possible to adapt to a given situation precisely because you have got to live it, and you have got to live it every day. But adapting does not mean that you forget. You go to the mill every day – it is always unacceptable to you, it has always been unacceptable to you, and it remains so for life – but you adapt in the sense that you cannot continue to live in a state of conflict with yourself
Steve Biko

Hope is definitely not the same thing as optimism. It is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out
Václav Havel

The only immorality ... is not to do what one has to do when one has to do it
Jean Anouilh

When old settlers say 'One has to understand the country', what they mean is, 'You have to get used to our ideas about the native'. They are saying, in effect, 'Learn our ideas, or otherwise get out; we don't want you.'
Doris Lessing

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INTRODUCTION

Personal Note

This situation analysis is an attempt to grasp the complex problems we face in the Department of Obstetrics & Gynaecology (DO&G) at both Kamuzu Central - and Bottom Hospital (KCH and BH). In listing and understanding these problems we hope to be able to find a successful and positive way to deal with them.

The need for such an analysis is great since only with an understanding of the problems at hand can there be hope to solve them.

The authors are a new member of staff and an old one. The new member is painfully aware of the fact that he is the latest addition to the department and therefore lacks some understanding, especially of the historic background of some of the problems we face. It is for this reason in particular that the combination of old and new is so important. We are very grateful to all our colleagues within and without the department, who helped us to find the information presented in this report. Having said that, we wish to make it clear that all errors contained in this report are entirely our own responsibility.

It is, however, not only a disadvantage to be new. It is also an advantage in that the newcomer observes with eyes not yet blinded by both assumed knowledge and sheer wont; or, even worse, by, quite literally, blinding frustration.

We sincerely hope that this report will reflect our genuine attempt to look at the situation with an open mind and an open heart.

Background

In order to understand the history of the DO&G it is important to look briefly at the country as a whole.

Malawi is a small land-locked country in Southern Africa dominated by Lake Malawi in the East. It has a total surface of 118.484 km² of which 94.276 km² are land. Its neighbours are Mozambique in the East and South-West, Zambia in the Northwest and Tanzania in the Northeast. It is divided into 27 administrative districts in three regions. The Northern-Central- and Southern Region. Lilongwe is the Capital of Central Region as well as the National Capital of Malawi (Figure 1).



Figure1 (Source: NSO 2004)

The climate in Malawi is tropical with two seasons. A dry season from May till October and a wet season from November till April. Temperatures and rainfalls vary with altitude.

History

The British explorer and medical doctor David Livingstone 'discovered' the country in 1859. In 1891 the country became a British colony under the

name 'British Protectorate of Nyasaland'. In 1953 it was joined with two other British colonies, Southern Rhodesia, which is now Zimbabwe, and Northern Rhodesia, which is Zambia, to form what was then called 'The Federation of Rhodesia and Nyasaland'. This federation lasted ten years until 1963. From 1963 until 1964 'Nyasaland' was a self-governing colony. By then 'the winds of change' had reached the country and in 1964 it became independent and took the name Malawi.

From its Independence on 6th July 1963 until the referendum on constitutional reform in 1993, Malawi became eventually a one-party state ruled by Dr Hastings Kamuzu Banda, himself a medical doctor, for 30 years. On 21st May 1994 his democratically elected successor Dr Bakili Muluzi, a businessman by profession, took power and ruled the country for ten years until he had to step down after two terms in office. After the general elections of 20th May 2004 he was succeeded by Dr Bingu wa Mutharika, an economist.

Malawi is member, amongst others, of the United Nations (UN), the World Trade Organization, the African Union and the Southern African Development Community. It is also a member of the African Caribbean Pacific – European Union relationship.

Population

The population size of Malawi in 1998 was 9.933.868 people. The majority lived in the Southern Region (4.633.968) followed by the Central Region (4.066.340) and the least populated Northern Region (1.233.560).

The population of Malawi has grown considerably over the last thirty years. From 5.547.460 in 1977 and 7.988.507 in 1987 and 9.933.868 in 1998 to an estimated 10.98 million in 2000. The percentage of people living in urban areas increased in the same time frame from 8.5% in 1977 to 14.0% in 1998. The same is true for the population density; this increased from 59/km² in 1977 to 105/km² in 1998 (NSO 1998).

This is also true for the Lilongwe District. Of all the Malawian districts Lilongwe is the most populated with a population of 1.346.360 people in 1998; Blantyre is the second most populated district with 809.397 people.

The Human Development Report 2004 (UNDP 2004) ranks Malawi with a Human Development Index (HDI)-value of 0.388 as number 165 out of 177 countries. This very low ranking is the result of low life expectancy of 37.8 years at birth, an adult literacy rate of only 61.8% and a Gross Domestic Product (GDP) per head of the population of only 580 US\$.

Looking at the trend of the HDI-value of the country is a sobering experience. The HDI for Malawi has not really changed from 0.315 in 1975 to the current 0.388. An HDI-value of < 0.438 is considered to indicate low

human development, while a HDI-value of > 0.438 but < 0.695 is considered to indicate medium human development (for instance Cameroon with an HDI-value of 0.501) and a value of > 0.915 indicates high human development.

When it comes to income poverty Malawi occupies the same rank amongst all nations of the world. Compared to other developing countries it ranks as number 83 out of 95!

The Official Development Assistance (ODA) received by Malawi in 2002 was 377.1 million US\$, this translates into 31.8 US\$ per head of the population. The ODA amounts to 19.8% of the GDP.

The Government of Malawi spends 12.3% of the total government expenditure on Health. This is a huge part of the budget and shows considerable commitment (for comparison: Botswana 7.6%, but Mozambique 18.9%). On the other hand it only amounts to very little money; in fact to far too little!

The total per capita expenditure on Health in US\$ at average exchange rates is 13 US\$. The per capita government expenditure is just 4 US\$ or 30.8%!

Table 1: Annual Per Capita Expenditure on Health (average exchange rate US\$)

	Total	Government	Percentage Government
Malawi	13	4	30.8%
Botswana	190	126	66.3 %
Mozambique	11	8	72.7 %
UK	1835	1508	82.2 %
Germany	2412	1807	74.9 %
USA	4887	2168	44.4 %

Source: WHO 2004

It is clear that Malawi is a very poor country and that the population has very little to spend anyway and even less on health. The little that has to be spent on health then has to come to an even larger degree from the patients themselves (almost 70%) than in one of the richest countries, the United States of America (USA), in the world today (less than 60%).

History of the Hospitals

The British colonial rulers initially built two hospitals in Lilongwe in line with their prevailing ideas of the day that a colour bar had to be in place. The hospital for the 'natives' was built close to the river. It was built in 1937 and locally known as Lilongwe General Hospital. It had female and male surgical and medical wards and a ward for children. There was also a female and male Tuberculosis (TB) ward, a theatre and labour room, a

laboratory, offices and houses for staff. In 1938 an additional hospital for Asians was built within the same premises.

The first doctors to work at the hospital hailed from the United Kingdom (UK) followed later by colleagues from Israel, one of whom, Dr Potta, is said to have died of poisoning after being shouted at at work. In the early days there was at least one Malawian doctor, Dr Chilemba, working there.

The hospital for whites was called Top Hospital because it was situated further up and away from the river in what is now Area 3. Naturally then the other hospital was called Bottom Hospital. After Independence rich Malawians also went for treatment to this hospital. What used to be the Top Hospital later became the Community Health Service Unit (CHSU).

The first recorded Caesarean Section carried out in Malawi was performed by Dr Cronyn, a Scottish general surgeon, in Zomba in 1936, one year before the hospital in Lilongwe was built. The first specialist Obstetrician to work in the country was appointed in 1961 and the first Paediatrician, Dr Borgstein from the Netherlands, in 1964 (King M & King E 1992).

The area where KCH was erected on in 1977 was formerly known as Nangwagwa Village. This area is much further away from BH as was the old Top Hospital. The hospital was built by the Danish International Development Agency (DANIDA) with money from the Danish Government. It is said that the then Life President Dr Banda personally insisted that the new hospital should have several storeys. During the first ten years after Dr Banda's reign KCH was renamed Lilongwe Central Hospital only to be re-renamed KCH in late 2004.

The plan was to complete the project in three phases, whereby Maternity, and other units, should be built in the second phase. Unfortunately after completion of the first phase political problems arose and DANIDA stopped its engagement to eventually retreat from any activity in the whole country for many years. This had the effect that the DO&G was separated, torn apart really, as a result of the erection of KCH. Other units that were left behind were Psychiatry, TB, Ante Natal Care (ANC) and the Malawi Against Polio unit with its orthopaedic workshop. All units with the exception of Maternity were later handed over to the District Health Office (DHO).

Political Situation

At this point in time Malawi is at an important crossroad. All people working in the Malawian Health Sector for more than ten years and irrespective of their political affiliation say that 'things got much worse during the last ten years'. Since the election of the new President Dr

Bingu wa Mutharika confidence in his Government seems to grow. There is hope, very cautious, that ‘things will get better’.

Accuracy and Types of Data

Because the authors of this situation analysis are mainly working at BH there is a possibility that the situation at KCH has not been described in this analysis as accurately as the one at BH.

All the statistical data are derived from the sources given. The Ministry of Health[♦] (MOH) has formulated a policy statement that makes it clear how important accurate data are (MOHP 2003 A, MOHP 2003 B). While the Health Management Information Unit (HMIU) is constantly trying to improve the quality of data, it must be said that some data surely needs to be improved (HMIU 2003).

Maternal Mortality Rate (MMR) - Maternal Mortality Ratio (MMR)

Most of the national data are based on the Demographic and Health Surveys (DHS) of 1992, 1996 and 2000 (NSO 1994, NSO 1997, NSO 2001). At this very moment the next DHS is under way and we all are looking forward to its publication sometime in 2005. It is feared, however, that Maternal Mortality will be even higher this time!

Estimating the degree or severity of Maternal Mortality is very difficult (WHO/UNICEF 1997, WHO/UNICEF/UNFPA 2001, UNFPA 2003) and therefore all data given for it are prone to be challenged. Because of the difficulty to obtain accurate data on maternal deaths (MD), let alone the number of deliveries or even pregnancies, all numbers given in the literature on either the Maternal Mortality Rate (MMR) or the Maternal Mortality Ratio (MMR) are to be looked at with caution. The definition of an MD is the death of a woman while pregnant or within 42 days of termination of that pregnancy (Lawson et al 2001). The difference between the rate and the ratio of maternal deaths is as follows:

<i>Rate</i>	<i>Maternal Deaths per 100.000 Pregnancies</i>
	or
	<i>Maternal Deaths per 100.000 women in reproductive age group (15-49 years)</i>
<i>Ratio</i>	<i>Maternal Deaths per 100.000 live births</i>

[♦] The Ministry of Health (MOH) was previously known as Ministry of Health and Population (MOHP), this explains the difference in referencing!

It should be clear from this that even the definitions are not very clear cut and both ratio and rate are frequently used interchangeably, which is not correct. Having said that it probably does not matter too much, both MMR's are a rough guide telling us how severe the problem of pregnant women's deaths is.

Neonatal Death Rate (NNDR)

An indicator for obstetric care is the NNDR which is defined as the number of neonatal deaths per 1000 live births. A neonatal death is the death of a viable baby who was born alive and dies within 28 days after birth. The NNDR could be subdivided into early (first 7 days of life) and late (8-28 days) NNDR, whereby early NNDR would reflect more on the intrapartum care.

Stillbirth Rate (SBR)

This rate is defined as the number of stillbirths per 1000 births. A stillbirth is a viable baby born dead. The SBR is seen as a general indicator for the quality of obstetric care.

Perinatal Mortality Rate (PNMR)

The PNMR combines NNDR and SBR and is seen as the single most important, or most sensitive, indicator of obstetric care. The definition of a perinatal death is the death of a baby in the period between becoming viable, 28 weeks gestation or 1000g, and 7 days after delivery. The PNMR is defined as the number of perinatal deaths per 1000 births.

It is very interesting to note that the perinatal period is not the same for developed and developing countries because viability in the developed countries is felt to start from 24 weeks gestation or 500g and not 28 weeks gestation and 1000g!

The PNMR for developed countries is less than 6/1000 births, while in developing countries it ranges between 30 and 200/1000 births. South Africa, for instance has a PNMR 40/1000 births. It is estimated that in South Africa there are 27 perinatal deaths for each MD (PPIP 2001).

PHYSICAL SITUATION

Any DO&G has to cover two different medical fields, the field of Obstetrics and the field of Gynaecology. Obstetrics is also called Maternity by some.

Our Department is divided not only in a physical sense but also along the line dividing paying patients from non-paying. We care for the paying patients at KCH catering for their gynaecological and obstetrical needs, while we only attend to the gynaecological needs of non-paying patients at KCH. Obstetrical needs of non-paying patients are attended to at BH.

Division of the Department over two distinct locations

As has been mentioned in the introduction the Department of O&G is physically divided over the two locations KCH and BH.

In kilometres the distance is about five. In terms of time it takes to get to one of the locations from the other, the distance may vary between ten minutes and more than three hours depending on the availability of transport and the traffic situation.

There is a very small laboratory, blood bank, x-ray facility and pharmacy at BH. We also have a nursery for newborn babies. There is no Intensive Care Unit (ICU) and, except for the anaesthetists, who do come to BH every day for 24 hours now, and specialist paediatricians, who do come and do rounds at the nursery *when they have time*, no other medical personnel comes to BH on a more or less regular basis or at all.

Since all offices concerned with personnel are at KCH, many a times staff has to go there during working hours to sort out problems there. It is fair to say that BH is also socially far away from KCH.

Within BH there is yet another division. All ante natal patients who come for the ANC to BH but are seen there by nurses and CO's from the DHO. Only those patients with a problem are then sent to us. Subsequently our department is not involved with the programmes concerned with Prevention of Mother To Child Transmission (PMTCT) of the Human Immune Deficiency Virus (HIV). This programme is currently carried out by the University of North Carolina (UNC), an American university with a long history of collaboration with Malawi in the field of medical research, but will be taken over by the government in the very near future.

It is very clear that there are numerous divisions within our department. They are summarized in Table 2.

Table 2: Divisions within DO&G						
BH			KCH			
O&G	Maternity non paying	O&G	Gynaecology all			
	Referred ANC		Maternity paying			
	Referred PMTCT		ANC paying			
DHO	ANC non paying					
UNC	PMTCT	UNC	PMTCT			
			<i>Source: DO&G</i>			

Condition of Rooms and Buildings

Bottom

There are two big buildings at BH for our department. One building houses those women who have to be close to a maternity facility, coming from far, but who do not constitute a medical problem. The other building is for all high risk ante natal women, those in labour, those who have delivered with their babies. It houses the nursery, labour room, post natal rooms, high risk ante natal rooms and theatre.

Officially the DO&G has 96 beds at BH, with usually more than 150 patients being admitted on any given day.

On average there are 1200 patients housed in these buildings a month not including the family members who overcrowd the place even more especially during the night and the rains.

The condition of the buildings at BH is unacceptable. The water drainage - and sewage systems are not working properly with resulting overflowing especially during the rainy season. In an already overcrowded ward, this is a disastrous scenario considering the hygienic implications.

There are no public toilets throughout BH!

The buildings available for women in labour and after labour are insufficient. There is only enough space for ante natal patients who do not require any medical or nursing attention.

The Labour Room is built in such a way that one delivery bed is right next to another and there is no room for anyone other than the expecting mother and the health worker. There is no privacy whatsoever for the delivering women. The curtains between the delivery beds are mostly

broken but if not they would prevent the present hopelessly understaffed health workers to have an overview of the labour room.

The theatre is also in a condition that makes it all but impossible to guarantee sterile operations. The doors are more often broken than not and the patient and medical personal flow is such that sterility becomes a myth. This is mainly so because of the layout of the theatre and partly because the existing structures, such as doors, are not working.

Central

Our department has 80 beds at KCH with an average of 120 women being admitted. There is little doubt that this capacity is not sufficient.

The physical structure of KCH is much better. Unfortunately KCH is a four storey building with two lifts which work erratically. This means that transporting a (very sick) patient from one location within the hospital to another can be not only an awkward but actually a very stress and painful, if not downright life-threatening undertaking for the patient.

Kamuzu Central Hospital houses the Departments of Anaesthesiology, Dentistry, Medicine, Dermatology, Ophthalmology, Paediatrics, Radiology, Surgery, Urology, Casualty and O&G. There is an ICU with five beds run by the Department of Anaesthesiology and a Medium Care Unit with four beds run by the Department of Medicine.

All the supporting essential services, such as Pharmacy, Laboratory, Physiotherapy, Maintenance and the entire Administration are all housed at KCH. It needs to be said that one of the most important essential services is missing and that is Pathology!

In the immediate vicinity of KCH are the Central Medical Store, Kamuzu College of Nursing (KCN) and the Malawi College of Health Science (MCHS). The students of both institutions, student nurses and student clinical officers, are dispatched for their practicals to both KCH and BH.

The work of our department is carried out at Outpatient Department (OPD) I and II, theatre, and wards 3A (non-paying Gynaecology), 3B (paying Obstetrics) and 4B (paying Gynaecology).

As mentioned earlier, the rooms are physically not as bad as the ones at BH, but that is, unfortunately, not to say that they are fine. The main problem here seems to be to create and maintain a clean and pleasant environment for the patients through having the walls painted or having tubs that actually work.

The physical structure of the theatre and the very small labour room at 3B are fine.

Availability of Equipment

Bottom and Central

While it seems unavoidable to make mention, now and again, of missing consumables such as gloves or antibiotics for instance, this section is about permanent equipment, such as instruments or furniture for example and not consumables.

There is very little adequate equipment available on both locations of our department.

Apart from theatre, there is only one gynaecological chair that allows for proper gynaecologic examination of a patient; this chair is in 3A at KCH, far away from OPD and therefore not suitable for outpatients at KCH or any patient at BH.

The equipment needed to properly examine a patient, such as vaginal specula, swab holding forceps, disinfection material, lubricants, proper light source, etc, are either too few, inadequate, broken or not present at all!

Fortunately the department has two ultrasound (US) machines, one on each location. These machines were donated by the German Government through the Centrum für Internationale Migration (CIM) at requests made by former, CIM sponsored, members of staff Dr Vollert and Dr Hoyneck in 1996 and 1999 respectively. Both machines are locked away for safety reasons which make them somehow less accessible especially during the night. In KCH there are additional US possibilities through the Department of Radiology.

The equipment needed to carry out therapeutic procedures, either in theatre, OPD or on the wards is also not adequate. Many instruments are either damaged or simply not there. This leads obviously to inadequate and many a times improper procedures resulting in pain and ill health for the patient.

There is a big need to overhaul all the instruments and tools, ranging from scissors and forceps to suction machines and oxygen generators.

Some operation sets are incomplete which at times has lead to situations where caesarean sections had to be performed with the surgical blade directly in the hands of the surgeon!

There is a most pressing need in labour room for an adequate number of sphygmomanometers of sufficient quality to serve a very busy labour room for more than a few days.

The disarray in which many delivery beds are is appalling. Many beds have several holes of up to 15 cm diameter in the metal frame caused by rust. And quite a number of these beds have the wrong mattresses on them making it difficult to put the patient swiftly in lithotomy position if need be.

Most delivery packs do not contain scissors, either to carry out an episiotomy, or to cut the umbilical cord. If scissors are present then they usually are blunt and the patients do suffer considerable while an episiotomy is being chewed. If scissors are missing donated razor blades are used with very significant risks for the health worker trying to perform an episiotomy with them!

The laboratory facilities on which our department depends to no small degree does not have enough equipment too. Most of the time it is not possible to get even a Full Blood Count, not to mention more sophisticated investigations.

The autoclave at BH is broken for a long time which means that all instruments used there need to be carried to KCH for sterilization there and then to be brought back to BH.

It is difficult not to assume that BH is seen as an inferior annex to KCH where supplies do not need to be as urgently as at KCH. KCH most certainly is seen as a priority by the administration which is stationed at KCH.

A list of urgently needed equipment and furniture has just been submitted to headquarters.

Maintenance of Buildings and Equipment

Bottom and Central

The list mentioned in the last paragraph, if ever honoured, may, however, not divert our attention away from the fact that maintenance and safe storage of all equipment is a very essential aspect of our daily work; or should be. There is no clear policy as to how to safeguard equipment, both from abuse and stealing.

Fact is that maintenance is virtually not existing in our department or very insufficient in the hospital as a whole, as the chewing scissors used on our patients, the broken doors in theatre at BH, broken toilets for both

patients and staff, no light in the changing rooms at BH, broken light sources in KCH and BH, or the strong stench surrounding labour ward during the rainy season, to mention but a few things, all bear witness.

Communication between the two locations

The physical distance between KCH and BH does not only make life difficult when it comes to movement of patients and their families, health workers, equipment and consumables, but also, and very importantly so when it comes to information! It is very difficult to exchange information between the two locations. This is particularly a problem after hours and leads to many secondary problems!

Recently this situation has become unbearable because the unpaid telephone bill of the hospital, apparently 27 million Malawi Kwacha, has made it impossible to use the hospital phones. In order to cope with this situation, health workers either use their own mobile phones at their own expense, or the ambulance is used as a messenger or no communication is sought. This is clearly unacceptable and very dangerous for the patients but also for the health workers. It is even worse when the ambulance is used for other purposes, many times sanctioned by the administration at KCH. Then there simply is no transport at all! Full stop!

Another communication problem that is at least not made better by the physical separation of our department is the difficulties this brings for meetings. It will never be possible for us to hold a meeting whereby all members of staff are present at the same time, because that would mean that patients are totally left alone at one location without even a chance to reach them in case of an emergency. Quite apart from this, even accepting that not everybody will be able to attend a meeting of the department, attendance is discouraged by the mere fact that the two locations are so far apart. And even if that would not be discouraging, it is bad for the department if a health worker may need up to three hours travelling to attend a meeting of his/her own department.

STAFFING SITUATION

The National 'Human Resource' Crisis

The health sector in Malawi as a whole is in the middle of a severe staffing crisis! Health services in the country are provided by three main agencies. These are the MOH 60%, the Christian Health Association of Malawi (CHAM) 37% and the Ministry of Local Government 1%. The remaining 2% are provided for by the private sector, commercial companies and others.

Malawi has only 1.6 doctors and 28.6 nurses per 100.000 people. This compares unfavourably even to countries in the region.

	Botswana	South Africa	Tanzania	Malawi
Doctors	28.7	25.1	4.1	1.6
Nurses	241.0	140.0	85.2	28.6

Source: Martin-Staple 2004

When looking at this figures one needs to keep in mind that the clinical officers (CO) are not included!

Looking at the gap between current and required staff, including CO's, who are the true back bone of the Malawian health care system, gives a more acute picture of the crisis.

	MOHP target	Currently working	Currently vacant	Percentage actual staff to target
Doctors	433	139	294	32%
Nurses	8440	4717	3723	56%
CO's	1405	942	463	67%
Medical Assistant	1500	718	782	48%
Laboratory Technician	507	251	256	50%
Pharmacy Technician	285	93	192	32%
Environmental HO	1662	304	1358	18%

Source: Martin-Staple 2004

As if these numbers were not enough, more than 90% of CO's and registered nurses (RN) are working in urban areas, leaving rural areas severely under-served!

Staff Establishment for the Department versus Actual Staffing Situation

Before looking at the staffing situation in our department it is very important and only fair to say that the staff establishment for the hospital as put forward by the ministry is such that even if completely realised, is not likely to comprehensively serve the huge amount of patients in need of our services (Chiudzu 2003). The meagre staff establishment is, of course, a reflection of the desperate general state in which the health sector is at this point in time.

Clinicians

The staff establishment for the whole department when it comes to clinicians, according to information provided by the Head of the Department (HOD) is as follows:

Thirteen clinicians divided up into these categories:

- 8 Clinical Officers
- 1 Senior Clinical Officer
- 1 Registrar
- 3 Specialists

The actual situation is as follows:

Ten clinicians:

- 3 Clinical Officers
- 1 Senior Clinical Officer
- 1 Registrar
- 5 Specialists

Thus 3 out of 13 posts are not filled up, which means a shortage of clinicians of 23%!

Since the unannounced arrival of two UN volunteer specialists to the department the number of specialists is actually more than planned, which is not the same as 'more than needed'. While these specialists are in fact clearly needed and most welcome it needs to be said too, that each specialist needs supporting staff and an increase in specialists needs to be accompanied by a proportional increase in supporting clinicians and

nursing personnel. Failing to see this is a reflection of poor planning and communication.

We are lucky not only to have these additional two specialists, but also, and in the long run much more importantly, to have a Malawian specialist on the staff. The whole hospital has only four other Malawian specialists, two in Paediatrics one in Ophthalmology and one in Dentistry. We feel that it cannot be overemphasized how important it is to have Malawian specialists on the staff who are clearly not only the future of the departments they are working in, but who will be the ones to shape the future of health care delivery in this country. It is very interesting and encouraging to see that those three other departments, headed by Malawian colleagues, seem to be the most efficient and well run of the entire hospital. We feel that that cannot be a coincidence!

Nurses

The staffing situation of nurses is much worse than the bad one of clinicians.

For the whole KCH the staff establishment says there should be 532 nurses but there are only 230, of whom less than 20 are RN's, the rest being enrolled nurses (EN)! This means there is a shortage of nurses of a staggering 56.8% if we look just at the numbers alone! But it really needs to be emphasized that there are less than 20 RN in the whole hospital! Clearly the word crisis is quite appropriate here!

Since KCH and BH are administered as being one hospital no extra staff establishment does exist for BH alone. In order to understand the numbers give for KCH it needs to be mentioned that the numbers are listed in such a way as to allow for separate listing of nurses working in theatre and the paying ward (4B), since those nurses obviously work for other departments too. As of the time of writing this report the staffing for our department was as follows:

KCH		BH	
O&G:	21 EN & 3 RN	Labour:	8 EN & 2 RN
Theatre:	12 EN & 1 RN	Theatre:	6 EN & 1 RN
4B:	4 EN & 1 RN	Postnatal:	8 EN & 1 RN
		Nursery :	5 EN & 1 RN
Total:	37 EN & 5 RN	Total :	24 EN & 5 RN

With these numbers it is only possible to have 4 nurses in labour ward during the day and only 2 during the night. It needs to be remembered

that the midwife needs to go into theatre if there is a C/S to attend to the newborn baby. In that case there is only one midwife to look after the entire labour room, where more than 15 women can be in labour at any given moment!! Unfortunately this is not the worst it can and does get sometimes. If one midwife is sick or bereaved leaving only one other midwife on call that night and this midwife has to go to theatre to receive a baby, then the labour room is totally unattended!!

It is evident from these numbers that a reasonable service cannot be provided by so few nurses. Asking for that is asking for the Impossible!

The staffing situation for nurses is made more difficult by the ‘brain drain’ that has reached endemic proportions (Elliot 2004). Table 5 is an illustration of this.

Table 5: Nurses Lost in 2003					
Death	Retirement	Resignation	Reposting	Absconding	Total
6	6	32	17	5	66
	1 UK	4 UK 4 private 3 UNC 2 Zimbabwe 1 USA 18 ?		2 UK 2 private 1 ?	7 UK 6 private 3 UNC 2 Zim. 1 USA 19 ?
<i>Source: Matron's Office, KCH</i>					

Supporting staff

There are 27 auxiliary nurses working in the entire hospital, 3 of them are at BH. These auxiliaries are people with very, very little training in nursing who were employed to help the EN's and RN's working in the wards.

Other supporting staff, such as porters and cleaners, are working at both locations. At KCH there are currently 344 staff members of this category and at BH 96 in the staff establishment. While we were unable to ascertain the actual number of supporting staff working at KCH, the number for BH is 38, which translates into a shortage of 39,6%!

In summarizing the staffing situation the shortages are severe. There is a 56,8% shortage for nurses, a 39,6% shortage for supporting staff and a 23,0% shortage for clinicians! These shortages are all counted against a staff establishment that is, at least, challengeable as to its desirability and appropriateness.

It seems fair to say that the staffing situation is in a severe and very deep crisis. There simply is no way the staff can cope with the work load in any acceptable way.

'Lost' staff

There is a group of staff that is somehow lost in the whole system. These 'lost people' are from all department and we have our fair share of them too.

These are clinicians or nurses who went overseas to obtain additional qualifications. Most of the time they went for a one year course and come home with a master's degree in one or other primary health discipline.

Since the hospital does not have official posts for Primary Health Care (PHC) personnel, these people are still listed as being part of the departments they came from, while clearly not working there anymore. These members of staff are more often than not, highly motivated and ambitious and clearly the people one would want to keep in the service. It would be a waste of time and resources not to use their newly acquired skills effectively and force them back in the positions they held before they were trained.

There is clearly a task here for headquarters to take administrative steps to allow for proper accommodation of these colleagues.

Factors that aggravate the staffing situation even further

One of the most extraordinary phenomena, and probably quite unique to Malawi, is the 'tradition' to be paid for attending workshops and trainings. This has laid to a culture where people go to attend as many workshops as possible for economic reasons only. This has reached proportions that severally compromise the work in the department.

While the idea of workshops and further training is a good one, these trainings need to be organized in a way that does not allow the normal work to suffer. The most common workshops in attended by staff from our department are 'Kangaroo Care', 'Saving Newborn Lives', 'Breastfeeding', 'Infection Prevention' and 'STI'. Many of these workshops are unnecessarily long and health workers do not seem to share what they have learnt there with those colleagues who could not attend.

Much of what is taught on those workshops could be taught within the department.

But, of course, one has to face the fact that the remuneration, while totally against the idea of a learning situation, is, for many, pure necessity!

WORKLOAD

Tasks of the Department

Unfortunately neither the hospital nor the DO&G has something like a mission statement. It is not noted down what exactly the task of the department is and what we should strive for in our daily work. No short-, medium- or long-term goals are set out. Even some small hospitals in rural Africa do have such statements and there is no good reason why we shouldn't have one too (LMS 2000).

Having said that, it should however be clear that the main task of the department is to provide adequate health care to our patients. That should mean, care that is of high quality, adequate, swift, and friendly. In addition to that the department also has the task to teach the students who are coming to us properly. Further more it should also see it as its task to allow its permanent members to grow on the job.

Being a Department of Obstetrics and Gynaecology our department naturally has a significant role to play within the Reproductive Health Policy (RHP) as formulated by the MOH. According to this RHP the following are the components of reproductive health care in Malawi (MOHP 2002):

- Safe Motherhood
- Adolescent Reproductive Health
- Family Planning
- Prevention and management of STI/HIV/AIDS
- Prevention, early detection of and management of cervical-, prostate- and breast cancer
- Elimination of harmful practices and reduction of domestic violence and infertility

As a department in a central hospital supporting the districts in our region is yet another task. Lastly our voice should also be heard when it comes to national issues, such as policies formulated by the MOH or other issues.

A DO&G such as ours is also in a unique position to do research in general and into issues related to the RHP, such as harmful practices for instance, in particular. The department needs most definitely to see that as another essential task.

We see this as the absolute minimum and feel that the department has to discuss and formulate its mission.

Overview of the Department's place within the District and the Country

The geographical position in which our Department finds itself is clearly illustrated in Figure 1. Lilongwe district itself is shown in Figure 2 .

There are three regional Capitals, Mzuzu, Lilongwe and Blantyre. None of these has its own District Hospital. Instead they have all a so-called Central Hospital that serves as a District- and a Regional Referral Hospital. In addition to these three Central Hospitals (Mzuzu Central Hospital in Mzuzu; KCH in Lilongwe and Queen Elizabeth Central Hospital (QECH) in Blantyre) there is one more Central Hospital and that is in the former national Capital Zomba; Zomba Central Hospital.

There is no real Central Hospital for the whole country, but the geographical closeness of the Medical School, the College of Medicine (COM) in Blantyre to QECH does somehow predispose QECH to become a truly Central Hospital for Malawi one day.

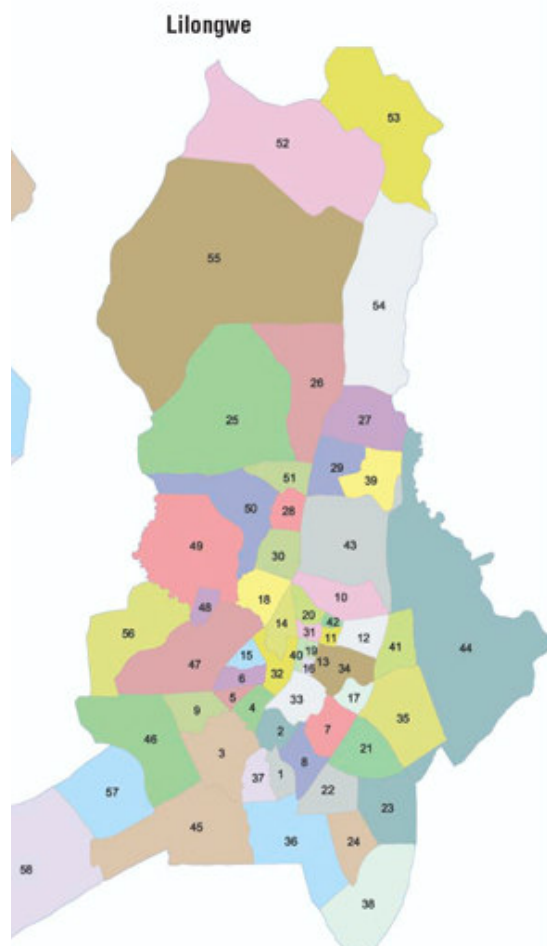


Figure 2 (Source: NSO 2004)

We are not aware of any plans by the MOH to create a truly Central Hospital, but it would certainly make sense to focus energies to one place especially in the light of the very restricted financial possibilities. One

example is the situation of Pathology in Malawi. Malawi has only three pathologists and none of them works fulltime for the Government. They are all attached to the COM. Of course efforts have to be undertaken to make sure every Regional Hospital has a Department of Pathology sometime in the future.

Kamuzu Central Hospital serves the whole region and therefore part of the task of our department is to go into the districts and support all the District Hospitals in our region. These are from North to South: Nkhotakota, Kasungu, Ntchisi, Dowa, Mchinji, Salima, Lilongwe, Dedza and Ntcheu.

The idea here is to support our colleagues in the districts practically by seeing actual patients on our visits. In addition to that training sessions are held to address the training needs indicated by our colleagues there. These visits should also serve to strengthen the cooperation between all district hospitals and the centre and by doing so to make the available services much more accessible to our patients. A strong region can only be achieved if all parts of it are strong and work together well.

Unfortunately these district visits have been quite erratic in the past due to understaffing. Because the staffing with specialists is much better at this point in time, the visits have been resumed in October 2004, albeit without clear instructions as to what is hoped to be achieved through them.

Patient Statistics

As mentioned earlier on the Population of the Central Region is 4.066.340 people. All these people form the catchments population for the Central Hospital part of KCH and BH. The District Hospital part of KCH and BH is looked at below.

Based on the numbers of 1998 the catchments population of our district is 1.346.360 people (NSO 1998). Based on the numbers compiled by the Lilongwe DHO the population was even bigger with 1.553.236 (DHO 2004). Lilongwe District has, whichever data are used, the largest population of all districts in the country!

The expected number of pregnant women in our district in 2004 was 105.588. The estimated number of women who will need emergency obstetric care was 11.649 and the number of expected deliveries throughout the district was estimated to be 77.662.

The Sexually Active Population was 776.618 people, 12.937 had a Sexually Transmitted Infection (STI).

There are no data on MMR in the district!!

The overall top five causes of death in the district were recorded as:

- 1 Other Communicable Disease
- 2 Malaria
- 3 Pneumonia
- 4 Anaemia
- 5 Other Non-Communicable Disease

Somehow surprisingly HIV/AIDS only ranked as 7th most common cause of death (DHO 2004).

In 2004 we had 11.760 deliveries in our department. That makes us one of the bigger maternities in the Southern Hemisphere!

Table 6 gives an overview of obstetric statistics of the DO&G for the years 2000 to 2004; it needs to be mentioned however that the data are flawed, since proper data collection is a serious problem.

Table 6: Obstetrics DO&G 2000 - 2004					
	2000	2001	2002	2003	2004
Deliveries	12.165	11.191	11.441	11.005	11.760
Live Births	11.792	11.013	11.202	10.709	11.201
MD	50	47	35	41	58
MDR	411/100.000	420/100.000	306/100.000	373/100.000	493/100.000
NND	446	161	409	425	356
NNDR	38/1000	14/1000	36/1000	40/1000	31/1000
SB	373	178	239	296	256
SBR	30/1000	16/1000	21/1000	27/1000	22/1000
RU	52	61	41	79	66
RU %	0.427 %	0.545 %	0.358 %	0.718 %	0.561%
C/S	1384	1161	1161	1564	1535
C/S %	11.38 %	10.37 %	10.15 %	14.21 %	13.05%

Source: DO&G 2003; DO&G 2004

In 2003 12.436 women were admitted to the obstetric wards in KCH and BH. Forty six patients suffered of eclampsia and 38 of pre-eclampsia.

Of the 2.850 patients who were admitted to the gynaecologic ward in KCH 42 had an ectopic pregnancy, 119 carcinoma of the cervix and 55 had a vesico-vaginal fistula.

Unfortunately there are no data on outpatients, except the 2.937 women who have been seen at the Family Planning Unit in the year 2003.

Students

More than 100 students are coming to our department each year to be instructed and trained.

About fifty 2nd-year and fifty 3rd-year students from the MCHS come for six and twelve months respectively. Six to eight intern Medical Officers (MO) from the COM come for 5 months divided between Obstetrics at BH and Gynaecology at KCH. The KCN sends about ten students a year to us.

In addition to that there are almost always some international nursing and medical students in the DO&G.

District Visits

The idea of visiting the districts is well established in the DO&G but due to staff shortages for specialists these were not carried out very frequently and consistently. Since there are five specialists now, the visits have resumed in October 2004; four specialists visit all the district hospitals in the Central Region. Since there are eight districts, Lilongwe district excluded, and one visit is scheduled a week, any given district is visited every eight weeks only.

RESULTS

Clinical Work

From the scarce data available concerning clinical work it is difficult to look at results at all. Too many questions cannot be answered with this data material.

What is known is this:

The obstetric interventions carried out in the DO&G in 2003 were 1564 C/Sections, 216 vacuum extractions, 0 forceps extractions, 64 subtotal hysterectomies and 130 tubal ligations.

The gynaecologic interventions carried out are not well documented. Apparently 2.121 major and minor operations were performed. No details are mentioned in the annual report (DO&G 2003).

No mention is made of the OPD work.

Teaching

Of all the students who have been in the department, all received a positive evaluation. No formal teaching programme is or was in force in the department. No teaching responsibilities are allocated to members of the department, no member is asked before the student is evaluated. The evaluation process is not at all transparent.

On top of this most students are allocated according to the needs of the department, rather than the needs of the students.

It is certainly fair to say that the training offered to students at DO&G is a disgrace and dangerous, considering the truth that the intern MO's and CO's will have to face obstetric patients in remote districts without a chance to consult with a senior colleague right after they leave our department.

Staff Turnover

The problem highlighted in table 3 does also affect the DO&G. In 2004 the Matron of BH resigned and moved to the UK and one of three experienced CO's at BH absconded to take up a position in the private sector. The midwife in charge of labour room was transferred.

All members of staff feel and say without hesitation that they would leave the department and take up a position in the private sector or overseas if they had a chance!

MEDICAL CHALLENGES

Maternal Mortality

Malawi, behind Sierra Leone, which is caught up in an endless civil war, is the country with the second highest MMR in the world today. The latest local figures are from the DHS 2000 and show a MMR of 1.120/100.000 which is double from the figures of 1996, when the MMR was said to be 620/100.000 (NSO 2001, NSO 1997)! The WHO even gives a MMR for Malawi in 2004 of 1.800/100.000 (WHO 2004).

This kind of MMR is almost unbelievable and certainly unacceptable! European countries have MMR's of around 10/100.000 and most countries in the region have rates of around 200/100.000! It is a reasonable question to ask whether a MMR as high as this one is something to which the health service has contributed in some way, since it does not seem to make evolutionary sense to have so many mothers dying, especially considering that many young children whose mothers have died tend to die as well.

Research done in the USA 20 years ago shows that the MMR in an American subpopulation where mothers refuse any intervention during childbirth is 872/100.000, which is much lower than the Malawian numbers (Kaunitz et al 1984).

Historically the MMR is said to have been as high as 2.350/100.000 in medieval Europe (Forbes 1971).

In the 1840's institutional MMR's of 9.900/100.000 have been reported in the University Clinics of Vienna or the Binnengasthuis in Amsterdam. These were overwhelmingly the results of puerperal sepsis, caused by examinations of labouring mothers by medical doctors- and students without gloves or washing hands between examinations, at a time when medical science did not recognise the role of micro organisms. In 1847 Dr Semmelweis was able to show the danger of unhygienic work but the results of his studies were ignored by the medical establishment until 1881 (Schuitemaker 1998).

Of course we all know that there are very many reasons for countries in this time and age to have high MMR's and therefore this problem has to be tackled at many fronts. For us at the DO&G the front should be clear. We have to deal with mothers who come to seek help very late in their struggle to deliver a baby. At a time when that struggle has changed into one for pure survival of the mother. Under those very urgent and difficult circumstances we need to be well prepared and well equipped to deal with these women. Especially in a situation where everything else seems to be in disarray we cannot afford to be understaffed and under-equipped and ill-prepared.

Those who cannot see that curative services are essential in the fight against MD's and feel that only PHC initiatives will be helpful and should be funded, do not understand that PHC and curative services have to work hand in hand; are, in fact, two sides of the same coin (Meguid 2001).

It is a scandal to see how much time and money is pumped into the 'Safe Motherhood Initiative' in this country, while one of the biggest Maternities on the African continent right here in the Capital of this very same country is lacking in the most basic equipment that is needed to save mothers.

Interpreting our statistics on maternal mortality, which show a MMR of between 306/100.000 and 411/100.000, is tricky. Institutional rates should not be compared with national rates without realizing that they are not the same. It is assumed that most mothers die outside of hospitals and therefore hospital rates need to be much lower than national ones. In addition to that it needs to be clear that one hospital, no matter how big, can only have a limited impact on national figures, but if the hospital's figures are close to the national ones then this particular hospital has not only no effect but a negative effect.

It is open for discussion how good our figures actually are, and this discussion is very much needed.

HIV/AIDS

Malawi is one of the most affected countries in the world when it comes to HIV/AIDS. There is no doubt that a high HIV prevalence contributes to a high MMR and NNDR.

Thanks to the UNC, a lot of research is going on in this area locally. While the UNC is interested mostly in conducting research, they also started and maintained the PMTCT programme. That is crucial if we want to fight AIDS effectively here. In the near future this programme will be taken over by the MOH and we should be prepared to take it over. We cannot afford to fail here.

The Department of Paediatrics (DP) is actively involved in this research. This is a very good thing, since the clinicians on the ground are much better equipped with the local knowledge needed to initiate research that is most likely to benefit our patients here.

For some strange reason the DO&G has not been interested to be involved in this research, and as a consequence is shut out of it. If we are serious about the threat HIV/AIDS constitutes for our patients, we have to get

actively involved in this. Many departments would feel very lucky indeed if they had this opportunity.

Quite apart from the research, because of the existence of the UNC-Lighthouse we are lucky to have an institution at hand where people can conduct voluntary counselling and testing and, if need be and certain criteria are met, even initiate and complete treatment. This is an opportunity which is too often left out.

Anaemia

Extremely many of our patients suffer of moderate to severe and sometimes extremely severe anaemia. Reasons for this are many, from malnutrition and chronic malaria, to intestinal parasites and multiple co-pathologies. When these women are pregnant the anaemia tends to become worse. Towards delivery or if and when any problem, such as Ante Partum Haemorrhage or the likes occurs, this anaemia can kill her.

Quite often the situation is acute when we see these patients in the department and the only reasonable thing we can do is to transfuse blood. To carry out a blood transfusion in KCH or BH is, however, not a straight forward thing. The so-called blood bank at BH is mostly broke. Then a CO has to go with blood samples of the patient for blood-typing and cross-matching to KCH, with all the troubles associated with getting transport. If he is lucky there is blood in KCH, if not he needs to find donors. Most of the time he will bring donors along in the first place if the patient was lucky enough to have them. Once this has been sorted out he will come back to BH as quickly as he can, again depending on transport! All this time the patient might be bleeding and many a times the CO will find only a corpse when he is back at BH!

This totally ridiculous way of dealing with life threatening situations is not acceptable! Accepting this is not accepting the inevitable, accepting this is accepting that coming to our hospitals when in dire need is the same as taking part in the lottery.

Eclampsia

Eclampsia is known to be a leading course of MD. It is also known to be treatable and if managed well will normally lead to a healthy mother and a healthy child.

For reasons not known to us the well recognized and well tested global treatment with Magnesium Sulphate and the policy to at least try to deliver the baby of an eclamptic mother vaginally if at all possible, was not the policy in the DO&G.

This has been rectified with success.

Postpartum Infections

Even though we cannot come up with statistics (DO&G 2003), there clearly are very many infections after delivery, especially after operative deliveries. It is of the highest importance to take note of the fact that post partum infections were found to be the leading cause of institutional maternal deaths in Malawi (Ratsma 2001)! While most women do survive these infections, unfortunately not all!, many do so with severe morbidity.

It cannot be claimed that a young eclamptic girl who had a C/S with subsequent sepsis and hysterectomy for a necrotic uterus and who leaves the hospital alive and without a living child, or even with a living child for that matter, was treated well.

Again there are very many possible reasons why we see so many infections. The possible explanations can range from overcrowded wards to poor hygiene during surgery, from poor surgical technique to high HIV prevalence, from poor postoperative care to inappropriate use of antibiotics. And we could go on and on.

While we cannot personally repair the doors of the theatre, we can and must make sure that all clinicians operating on our patients are properly trained and know how to operate well; we can make sure that we all use the same post operative regimens of antibiotics; we can make sure that patients are looked after well postoperatively and so on. Having said that, we also have the duty to continue to cry for help that the doors of the theatre will one day be repaired.

Evacuations

Possibly due to a combination of understaffing, powerlessness on the part of the patients and poor ethics, evacuations are not carried out when needed, but when time and space is made available in theatre. This could lead to situations where a woman has to wait for up to a week!! Before she has her evacuation!

Suspected Poor Surgical Techniques

Due to poor teaching and supervision surgical techniques tend to become outdated and also performed poorly. The most important surgical intervention carried out in our department is C/S. No revision of surgical techniques has taken place for many years.

Initiatives have started to rectify this situation.

Poor Neonatal Outcomes

Malawi is said to have a PNMR of 45.9/1000 births (NSO 2001). This is a PNMR which lies within the expected range for a country in this region. Given the fact that usually the PNMR would be much higher than the MMR, it is doubtful whether this is in fact true.

From the data given in the DO&G annual report the PRNM cannot be calculated. No difference is made between early and late NND's. Information on abortions, let alone viability, is not given.

The NNDR and SBR are not good and need to be discussed within the department but also together with the paediatricians. Something that should be routine but is not done at all at this point in time.

PROBLEMS

Discipline within the Department

There is no doubt at all that there is almost no discipline in the department nor in the hospital as a whole. While we did research for this analysis we have heard repeatedly and by almost everyone we spoke to that there is no discipline at their place of work too!

Health workers of all levels do not come to work on time, sometimes at all, without giving prior notice; even without saying anything at all. Health workers are not at their stations when they have to be there without informing anyone.

After seeing a patient health workers write down their notes but take no action to ensure that the orders will be carried out.

In short there is very, very little sense of responsibility. Too little, in fact, to be entrusted with the lives of other people!

The Hospital Director and the Permanent Secretary are aware of this, but their advice to follow civil servant rules and warn such a person three times and then have him or her dismissed is a hollow one, and we suppose they know that. The problem is, of course, that we are already, as has been shown here once more, totally understaffed and if we get rid of such an undisciplined colleague and do not get someone else in return we are actually worse off.

And nobody asks here whether this is fair to our patients!

To be fair to all the health workers it has to be said that there are very many colleagues who are extremely responsible and who do work their heads off. They are the true back bone of our department and the unsung heroes of our patients!

Management of the Department

It is not at all apparent how our department is lead and in which direction.

No daily meetings are initiated. The only two regular meetings are one academic meeting and one administrative meeting a month. Many a times the HOD is not present, due to other commitments, at these meetings if they are held at all.

There is no clear philosophy as to how the department should work. No clarity as to what the goals are.

It is also not clear how the hospital director communicates with the HOD and in which meetings our department is represented or should be represented. It is not clear what the visiting specialists are supposed to do when they go to the districts, nor is there any medical discussion over patients other than ad hoc.

There is a lack of vision, mission and philosophy; and above all communication.

Communication

As mentioned earlier, and in fact just in the previous paragraph, communication is a very big problem.

At this very moment in time the biggest material obstacle is the fact that the telephone is not working properly.

Transport

We have made mention of the debilitating problem of having to work on two locations and we have mentioned too the fact that transport between KCH and BH is very difficult.

Through the RHU we were able to get an ambulance to be exclusively assigned to maternity at BH. This ambulance would then help us to overcome the severe transport problems. This new ambulance which came in September 2004, was to be stationed at BH. It would be an addition to the already existing one which is used by all who work at BH, not just maternity.

This new ambulance never actually worked!

Our department has spend an enormous amount of time to get this ambulance to BH but up to today neither the Hospital Director, the Administrator or the Transport Officer where able or willing to release the ambulance.

Clinicians on call

All the problems described in this analysis are more acute and more difficult to overcome during the night when only one clinician is first on call for both KCH and BH.

This alone is an insult to our patients.

Maternity alone at BH would require two clinicians to be first on call, but to have only one for BH and KCH at the same time is impossible.

Another big problem is created by the way we run the system of locums who help out with calls. While they are most welcome to do on calls for us, (it would just be impossible to have the nights covered without them), the locums do create a problem in that they are never there when their call ends because they have to be in the department where they normally work. It is therefore very difficult and sometimes downright impossible to ascertain what has actually happened during the call. Valuable and sometimes crucial information is lost in that way. This goes both ways. Neither are we able to see what the locum thought nor can he know what we think. This has created many, sometimes fatal, problems.

Asking for Assistance

There is a culture of not asking for assistance within our department. This is true both horizontally and vertically. The reason for this might well be the lack of general communication and transparency.

Whatever the reason it clearly increases the chances for mishaps and endangers patients totally unnecessarily. In the end the mothers and their babies are the ones who will ultimately pay the price if needed assistance is not provided because the health worker responsible, at whichever level, did not seek assistance.

The Veterinary Appeal of Gynaecology

As it is outpatients are seen by whoever has time to run the clinic and patients are more likely than not to see another clinician when they have to come back. Even if they have to undergo an operation they are very unlikely to be operated by the person who said they needed the operation in the first place and also the follow up afterwards will in all likelihood be done by yet another person.

This has been called, very rightly so, the veterinary appeal of gynaecology in poor countries (Fathalla 1997). In 2005 there should be no place for treating women in such a way.

Frightened Lonely Women in Labour

Most if not all women in our labour ward do deliver all alone without a personal companion. This is particularly hard for young primigravidae. Some of these women are as young as 12 years. There is evidence that women who undergo delivery with a companion do need fewer interventions and have better outcomes than those who are all alone.

Clearly there must be a way to accommodate this knowledge and to support our patients in this regard much better. Lack of adequate emotional support for our patients, surely, is a major factor why women seek the help of Traditional Birth Attendants (TBA) even if they fall into a risk group and know they should deliver in a hospital.

Frustrations

It is obvious to an almost obscene level that most, if not all, health workers at KCH and BH are utterly frustrated, some even to the point of despair. This frustration is palpable and extremely difficult to disperse especially since it is so very understandable.

The salaries are so low that a decent life where all basic needs, which naturally need to include schooling of the children, are catered for is not possible. This makes it all but impossible for the health worker to give the patient his or her best, since there are always worries about the most basic things in life. How am I going to pay the rent this month? We cannot afford to send my child to a good school anymore! I need to nock of early otherwise I cannot afford a taxi! What am I going to feed my family? Etc.

Even if the health worker manages to forget for the time he spends in hospital those profound worries, he finds himself in a working place where the most basic tools are missing. He has to go through an endless ritual and process of looking all over the premises to find the necessary tools, or to find out that they are just not there. How can he perform a C/S in such a way as to create minimal tissue damage in order to avoid necrosis and sepsis postoperatively, if he has no scissors, not a single pair in the whole set, that is not blunt like a baby toy?

Still, even if he manages to find the right tools for his job he will not have a colleague to assist him because that colleague went away to collect his salary at KCH and needs two hours for it because there is no transport. Because he has no assistance he cannot do what he needs to do or he can only do it when it is (too) late or he does it alone but not as well as he would have with assistance.

We can go on and on, and everyone who reads this situation analysis, whether he or she be working right here in the hospital or at a desk at

headquarters or elsewhere in Malawi and who has been exposed to the hospital setting knows exactly what we are talking about!

It is important to mention at this point the frustrations felt by those in leading positions who have been writing letter after letter after letter to headquarters without adequate reply, or any reply at all for years on end!

There is a strong sense of being left alone in the dark!

Again the question needs to be asked: How serious are we taking our patients? A cynic might say that we do not take our patients serious at all and the reason for that is simple: they are poor, female and voiceless!

And what about the babies?

Also here the physical separation between maternity and the DP, which is housed at KCH, makes a successful cooperation extremely difficult and in case of emergencies virtually impossible.

In addition to this no meetings with the DP are held. All contacts are ad hoc. Here too, the total lack of communication is appallingly apparent. Children, especially very small children are even more in need of protection and care and advocacy than women. We certainly fail them across the board!

Corruption

There are many anecdotal signs for wide spread corruption within the hospital in general and also within the DO&G in particular. Patients are said to have been asked by health workers to pay for services that should be free; it is said that procedures have been carried out against an additional fee, or patients are offered the possibility of paying less than the nominal fee without receiving a receipt for a payable service, or paying to receive a service quicker. This should and does not only have ethical implications but criminal ones too!

Corruption is also part of the symptoms of a sick department or institution and reflects poorly on the structure and organization of the department or institution.

Offices

The DO&G has no proper office space for its members. All the administrative tasks are carried out at home on equipment owned by the staff member, or not at all. This is a situation that is not conducive for

good administration! It weakens the department much more than seems apparent at first sight.

POSSIBLE SOLUTIONS

Anything that is said here has to be seen in the wider context of very, very limited resources, be they 'financial' or 'human'. Instead of not doing anything, the following could at least be tried.

Change of Management Style

Philosophy

There is no doubt that our department is in dire need of strong and decisive management with a clear and transparent philosophy and vision for the future supported both by the people working in the department and the administration at the helm of the hospital and headquarters.

A process needs to be initiated to swiftly formulate the philosophy, vision and mission of the department and then engage all those working in the department to adhere to it.

While we cannot hope to generate the necessary financial means in order to bind our colleagues to the department through economic incentives, what we can try to do is to make the working environment such that our colleagues have the feeling that they are growing within the department professionally and perhaps even personally.

This can be achieved through regular, daily meetings whereby medical/patient problems are discussed and a lot of teaching is taking place.

Research into problems that affect us has to be initiated and conducted and published with the names of all those involved in the study acknowledged.

Local, national, regional and international conferences should be visited and their contribution to our knowledge or policies be shared with those colleague who have not been there.

We need to become proud again in and of what we do! Our task is enormous and very much worth while. This has to be communicated to the entire staff in a friendly, engaging and intelligent way and above all, every day!

We need also to see the contribution each and every member of staff is making and acknowledge him or her for it. This, of course, also includes the irresponsible contributions.

In addition to all this it should be clear to all of us that the DO&G of the Central Hospital of the Capital of Malawi should, in the long run, be headed, if at all possible, by a Malawian. Why could it not be organized that the handing over of this responsibility takes place slowly and gradually, starting as soon as possible?

RECOMMENDATIONS

We feel that the first three recommendations are the most important ones and really need to be followed up!

Philosophy

There is no need to repeat what has been said above on this point but it certainly is the first thing that needs to be tackled (Pendleton & King 2002).

Discipline

It is, unfortunately, not realistic to think that all discipline will come back through friendly means only, but it might help. To really be able to discipline a colleague needs the co-operation of the administration and headquarters and most people have very little hope that that will happen.

Physical Separation within the Department

It should be a priority to ensure that Maternity will move to KCH. This move will solve many problems for our patients. The DO&G should advocate this wherever possible and neither the MOH nor the general public should be left in any doubt about the usefulness of such a move. In addition to moving maternity to KCH, the maternity needs to be expanded in order to accommodate our patients humanely and to demonstrate that we take 'Safe Motherhood' seriously.

While working on those three urgently needed changes, the following has to happen simultaneously.

Calls

The problem of the clinicians being on call on two locations simultaneously needs, once more, to be brought to the attention of the administration. Ultimately the question needs to be asked how serious we take the fate of our patients? If the administration cannot help in this headquarters need to be approached for assistance.

Locums

The HOD's of all departments need to meet urgently to discuss and decide that locums should report at and to the department where they had been working the previous night and only after this morning report return to their own department.

Transport

The ambulance designated to Maternity needs to be wrestled off the transport department. If need be the people from the RHU who donated the car in the first place should be used to put pressure on the administration of KCH. After more than three months that would be quite in order.

Humane Treatment of Women

A plan has been worked out how women can be seen in such a way as to allow for more humane encounters between her and the health care provider ensuring that she would, if at all possible, be seen by the same person each time she comes. This plan needs to be introduced wholeheartedly and immediately.

Infections

A rigorous policy needs to be implemented urgently to fight infections in the department. Part of this could be the use of honey-dressings as advocated and practised successfully in various other hospitals in Malawi (Peller 2005).

Surgical Techniques

Evidence based techniques, such as for instance the Misgav Ladach method for caesarean section need to be introduced as a matter of routine (Holmgren et al 1999; Hema & Johanson 2001; Lee-Parritz 2004). Supervision needs to become a basic routine activity whenever surgery is carried out.

Evacuations

A discussion should be started as to how to insure that evacuations will be done the moment a woman needs it. It could be discussed whether a special room could be assigned to this and the procedure be carried out under Pethidin/Valium as is done in many countries.

Frustrations

While the frustrations are very understandable they are not to be used as an excuse not to try to improve. A prominent football coach used to say to his team *'The game is over when the game is over'* which means as long as we are working we should and shall not give up hope (Winsemius 2004). This is the least we owe our patients. There is no excuse for allowing frustrations to prevent us from caring for our patients in the best possible way.

Paediatrics

Regular meetings with the DP have to be initiated immediately! The paediatricians are eager to engage in discussions and we, as a department and as individual health worker, and, above all, our patients, can only benefit from this.

Annual Reports

The Annual Reports need to be of a much higher quality allowing for real scrutiny and evaluation and appreciation of the work done by the DO&G.

Students

The teaching of students need to be formalized and this task needs to be re-appreciated. It would be good to cooperate closely with both teaching institutions, KCN and MCHS, which are so close to KCH.

Research

The very recent tentative steps undertaken by the DO&G to conduct research should be actively encouraged. In addition a meeting should be organized with the UNC representative and the DP to investigate and discuss possibilities to jointly conduct research in the future.

PHC

The department needs to start discussions with the MOH to find ways to integrate those clinicians who have been trained elsewhere in order to obtain additional qualifications into the hospital work. An urgent example is the upcoming takeover of the PMTCT programme which needs to be handled well.

Districts

A clear plan needs to be drawn up in which the district visits, their purpose, form and frequency, are noted down. This plan needs to include guidelines that will help us to improve the collaboration between districts and central hospital.

Corruption

There is a need for a clear policy concerning corruption. This very serious problem needs to be addressed in conjunction with senior hospital administration.

Future

While what follows here is realistically not possible in the very near future, it still needs to be mentioned because the need for it is urgent and apparent.

We have to see to it that these aspects are not forgotten and that we, as a department, but also as a hospital and as a ministry of health, will not allow circumstances to get us to loose sight of what we should work for.

Pathology-Oncology

If we want to serve our patients well we need a functioning department of Pathology right here at KCH, or at least in Lilongwe. It seems the CHSU has a laboratory with the appropriate equipment for pathological examinations; it is therefore possible to work from there if a pathologist could, even on a part time basis, be made available. This would be in line with the RHP of the MOH which specifically makes note of detection and management of cervical cancer. A functioning oncological service is not conceivable without Pathology. But Pathology is not confined to Oncology alone, it should be part and parcel of any surgical service!

Laparoscopy

In this time and age Laparoscopy should be part of the routine armament in any Central Hospital in the world, also in Malawi (Meguid 1997). There is no reason why we should deny our patients this diagnostic and therapeutic tool.

Perinatal Medicine

There is a need to improve on the services given to neonates and the unborn babies. This requires a neonatal ICU and more sophisticated laboratory facilities.

Labour Room

We should work towards a change in attitude towards our patients in general and the women in labour in particular. Why can we not allow each woman to bring a female companion inside the new labour room to be with her for physical and emotional support?

CLOSING REMARKS TO THE READER

We hope sincerely that this situation analysis will help to improve the services offered and given to the women who need them so urgently and desperately.

We are also wide open for criticism this analysis might provoke. Please, if you feel you want to comment on anything mentioned here or left out, call on us.

Most of all we want this analysis to lead to actual and immediate change for the better.

TM
EM

Contact:

Department of Obstetrics & Gynaecology, Kamuzu Central Hospital
PO Box 149, Lilongwe

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
BH	Bottom Hospital
CHAM	Christian Health Association of Malawi
CHSU	Community Health Service Unit
CIM	Centrum für Internationale Migration
CO	Clinical Officer
COM	College of Medicine
C/S	Caesarean Section
DANIDA	Danish International Development Agency
DCM	Diploma in Clinical Medicine
DHO	District Health Office(r)
DHS	Demographic and Health Survey
DO&G	Department of Obstetrics & Gynaecology
DP	Department of Paediatrics
DTM&H	Diploma in Tropical Medicine & Hygiene
EN	Enrolled Nurse
GDP	Gross Domestic Product
GP	General Practitioner
GTZ	Gesellschaft für Technische Zusammenarbeit
HDI	Human Development Index
HIV	Human Immune Deficiency Virus
HMIU	Health Management Information Unit
HOD	Head of Department
HPU	Health Planning Unit
ICU	Intensive Care Unit
KCH	Kamuzu Central Hospital
KCN	Kamuzu College of Nursing
LMS	Lutheran Medical Service
LUMC	Leids Universitair Medisch Centrum
MCHS	Malawi College of Health Science
MCM	Medical Council of Malawi
MD	Maternal Death / Medical Doctor
MMR	Maternal Mortality Rate / Maternal Mortality Ratio
MO	Medical Officer
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MPhil	Master of Philosophy
NND	Neonatal Death

NNDR	Neonatal Death Rate
NSO	National Statistical Office
ODA	Official Development Assistance
O&G	Obstetrics & Gynaecology
OPD	Out Patient Department
PHC	Primary Health Care
PMTCT	Prevention of Mother To Child Transmission
PNMR	Perinatal Mortality Rate
PPIP	Perinatal Problem Identification Programme
QECH	Queen Elizabeth Central Hospital
RCOG	Royal College of Obstetricians and Gynaecologists
RHP	Reproductive Health Policy
RHU	Reproductive Health Unit
RN	Registered Nurse
RU	Ruptured Uterus
SB	Stillbirth
SBR	Stillbirth Rate
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UK	United Kingdom
UN	United Nations
UNC	University of North Carolina
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	Ultrasound
USA	United States of America
US\$	United States Dollar
WHO	World Health Organisation

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People consulted

Mrs Trish Araru, Consultant, HPU, MOH

Dr Colin Bullough, Gynaecologist, formerly, DO&G, KCH & BH

Mr Bornwell Chapalapata, Transport Officer, KCH

Mrs Angela Chiotcha, Matron, Theatre KCH & BH

Dr Grace Chiudzu, Gynaecologist, DO&G, KCH & BH

Ms Beth Deutsch, Consultant, RHU, MOH

Dr Fritz Driessen, Gynaecologist, formerly, DO&G, KCH & BH

Dr Howard Friend, GP, British High Commission, Lilongwe

Mrs Fannie Kachale, Chief Matron, KCH

Mrs Dorothy Kamanga, Matron, BH

Dr Chrissie Kaponda, Director, KCN

Dr Damson Kathyola, Hospital Director, KCH & BH

Mrs Evelyne Katimbe, EN, BH

Dr Peter Kazembe, Paediatrician, HOD, DP, KCH & BH

Mrs Flora Kuthyola, EN, BH

Ms Juliana Lunguzi, Consultant, RHU, MOH

Dr Alice Maida, DHO, Lilongwe

Mr Harold Masanda, Human Resource Officer, KCH

Mr Chris Moyo, HOD HMIU, MOH

Mr Frank Mpotha, Senior CO, MCHS

Dr Susan Mshelia, Gynaecologist, DO&G, KCH & BH

Dr Sara Munthali, Deputy DHO, Lilongwe

Mrs Ruth Mwale, Deputy Chief Matron, KCH

Mr Kentridge Mwaungulu, CO DO&G, KCH & BH

Dr Rita Peller, Surgeon, Machinga District Hospital, Liwonde

Dr Susanne Pritze-Aliassime, Health Coordinator, GTZ, Lilongwe

Dr Esther Ratsma, Consultant, Zomba

Dr Bernhard Reich, Gynaecologist, HOD DO&G, KCH & BH

Dr Jos van Roosmalen, Gynaecologist, LUMC, Leiden

Mr Asgeir Rustad, First Secretary, Royal Norwegian Embassy, Lilongwe

Dr Nasinuku Saukila, Intern MO, DO&G, KCH & BH

Dr Elisabeth Vrolijk, GP, Amsterdam

* unfortunately it proved impossible to see the Permanent Secretary of the MOH