ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

I spent a total of 6 weeks working in a hospital in Zomba, a small town in southern Malawi with a population of just over 100,000 people. I undertook my elective in Zomba Central Hospital, the main hospital of Zomba district and also the referral hospital for all high-risk/complicated pregnancies in the district. Together with 2 friends I travelled to Zomba to spend my elective working in the obstetrics and gynaecology unit, shadowing the team in the antenatal, post-natal and labour wards and attending theatre for both elective and emergency cesearean sections. We organised the placement through a UK based charity called Maternity Worldwide, a charity which was set up to advocate for women's rights and tackle the issues and dangers surrounding childbirth in the developing world.

Our days started with a morning meeting chaired by our supervisor, Dr Kabeya, the O+G consultant leading the department in the hospital. This morning meeting would highlight cases from the previous day which merited discussion and questions, and would be used as a tool for teaching the junior interns and midwives, highlighting important learning points relating to each case which was discussed. All elective caesaerean sections were discussed, and indications for each were detailed and explained. Dr Kabeya invited questions from all the participants, and it was a useful experience for us as it allowed us to get an idea of common indications for sections as well as common complications and how they are dealt with. The hospital was a referral hospital for complicated pregnancies and women identified to be at higher risk of obstetric complications, identified mainly in antenatal visits. From our time on the labour ward, and from speaking to the midwives, we were able to get an idea of which cases were most commonly seen/referred. These included pre-eclampsia and eclampsia, women with a history of previous obstetric complications, diabetic mothers, multiple gestations and women with pre-existing medical conditions such as epilepsy or malnutrition. When comparing this with my experience of obstetrics in the UK, several things stood out to me. One of the major differences was the antenatal care. Women would have, on average, 4 antenatal visits where they would see a midwife who would measure their blood pressure, weigh them, and ask them specific questions depending on their gestation. They would then be examined, and finally they would be given medications again dependant on their gestation. All pregnant women would be prescribed folic acid and iron, regardless of their haemoglobin counts. Unless there was a contra-indication (e.g. they were taking anti-retrovirals), all pregnant women would be given a course of anti-malarial medication to take from week 16 onwards, and they would also be given worming tablets (albendazole) as a stat dose in their second trimester. Contrary to the UK, booking visits would usually only include very basic blood tests (full blood count and HIV status were always checked), and women would generally only be scanned if there was concern over the growth of the baby (usually identified by small fundal height or discordant fundal height according to dates). This lack of access to scanning and reliance on the woman's self-reporting of her last menstrual period meant that there was often inaccuracy in correctly establishing gestation, and this lead to problems when it came to planning elective casearean sections. On one occasion, an error was made in correctly calculating a woman's gestation and she was delivered too early and unfortunately lost the baby as the hospital did not have the resources to support a baby who'd been born so prematurely. This was very difficult to come to terms with, as I could never imagine that situation arising in the UK.

With regard to provision of health care and how this differs from the UK; the hospital we were placed at was able to offer free care to all those who could not pay for it. All antenatal consultations and medications were free, and when the women came in to deliver their babies there would be no fee, similarly to the UK. The labour ward had one 'paying room', and the midwives explained that if a lady chose to pay for this private room and the one-to-one nursing that came with it, this money would be used by the hosopital to fund the care of others who could not otherwise afford it. In terms of the facilities available, there were 15 beds in the labour ward and around 30-40 beds in both the antenatal and post-natal wards. Women would be kept in the antenatal ward, proceed to the labour ward when they had been examined and found to be in labour, and then transferred to the post-natal ward once they had delivered. There were no forceps available (we were told the use of forceps was banned in Malawi as there are concerns over lack of training in using them), and there was one Kiwi cup for instrumental delivery (which we never saw being used). One of the most striking things that I found, and that has stuck firmly in my mind, was the resilience and strength of the women we met who were giving birth. The only women who were offered any form of pain relief/anaesthesia were those undergoing c-sections. There was no pain relief available on the labour ward at all, barely even a paracetamol! It was quite something to walk into a labour ward and only hear the occasional loud shout or cry, knowing that perhaps 3 or 4 women were delivering at the time with no pain relief whatsoever.

I learnt an awful lot through this elective, from the patients as much as from the doctors and midwives. The staff who we met were extraordinary. They made the most from the resources they had, and worked tirelessly day and night attending to their patients. They had to make the most of the limited resources they had available, and although it was frustrating at times they always had a smile on their face and were always willing to teach us and let us observe their practice. We saw a completely different type of medicine in Malawi … from simple things we take for granted, like not having a CTG machine in the hospital and having to rely on hands-on clinical examination skills to determine if labour was not progressing as it should, to more complex issues around lack of training and experience leading to mistakes being made. It was a challenge to say the least, but one of the most interesting and rewarding experiences that I've been lucky enough to enjoy. I feel I have taken a lot away from this time, and I know that what I've learnt will help me throughout the rest of my career.