Eleanor Bradley Fellowship Final Report

August 2008 – September 2009

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Mulago Hospital Complex is the National Referral Hospital for the whole of Uganda, as well as serving the fast growing capitol city of Kampala. The obstetrics and gynaecology department is very busy with over 33,000 deliveries/ year. It is also the main teaching institution for undergraduate and post graduate medical training in Uganda. It is chronically busy, under staffed and lacking basic equipment and drugs. Maternal death is unfortunately a common problem; between 3-4/week; yet Mulago can be a very rewarding place to work. Throughout the year that I have spent here I have seen definite changes, and I truly look forward to returning in the future and seeing many more.

I strongly believe that the concept of this fellowship is sound. As an individual I have benefited greatly from my time here, I have been able to contribute actively to the department, safe in the knowledge that anything that I setup can be continued by the next fellow. I hope that support for the fellowship will grow and more similar fellowships can develop.

Throughout the year I have mainly done clinical work, but I have also worked on a variety of other carefully chosen initiatives in order to make useful and sustainable improvements to patient care in **Mulago.**

Clinical work

The first two months were spent rotating a week in each sub-speciality and on the acute wards; labour ward and 5A annexe (acute gynae emergencies) in order to acclimatise to the new way of working. Then I went onto the SHO/post graduates rota for the rest of the year. I rotated with a group of SHOs through the various sub-specialities; general gynaecology, family planning, gynae oncology, urogynaecology and materno-fetal medicine. Here I worked as another SHO on the rota attending clinics, theatre sessions, leading/participating ward rounds, teaching students and weekend ward cover. Labour ward and 5A annexe sessions are for a whole week every month plus evenings or nights. On the acute wards I was often super numery except during exam times. The last two months were spent in theatre and labour ward as I felt here I could learn the most directly transferable skills. I learnt different lessons and skills on different wards and often found myself in situations that would never arise in the U.K, however although sometimes very challenging I feel I coped well and have learnt a great deal.

General gynaecology – I found this ward the most challenging as the pathology varied widely and the language barriers were therefore more difficult. Common pathologies include fibroids (at term), ovarian cysts, molar pregnancy, post-op ectopics, pelvic abscesses and early pregnancy problems. I was able to perform several suction curettages, assist several transabdominal hysterectomies and independently manage many of the above conditions.

Family planning – This sub-speciality has now been merged into general gynae as it is so quiet. I assisted several myomectomies (that often turned into TAH), enjoyed OPD and learning to interpret the different investigations, counselling and talking to the patients was very rewarding when they spoke English and saw salpingolysis for the first time. During this period an American consultant led team came over, with a variety of laparoscopy equipment, in order to teach laparoscopy. This was a very interesting few days, I learnt a lot as well as helping them to teach and mobilise patients etc.

Gynaecology oncology – This was one of my favourite areas; I saw a phenomenal spectrum of disease and some amazing surgery. The specialists were often around so it was well supported and ward rounds were teaching ward rounds. I had hands on experience of managing many advanced malignancies not commonly seen in the U.K especially advanced carcinoma of the cervix and choriocarcinoma.

Materno-foetal medicine – This is my natural area of interest so I found it fascinating. There are always so many patients that it can be overwhelming, especially as it was exam time when I was on MFM so often alone with the intern. However I managed many cases particularly multiple pregnancy, medical disorders in pregnancy especially PET, malaria and latent labour, as well as doing many elective C-Sections mostly for women with previous CS scars.

Urogynaecology – I rotated here twice as well as doing the "urogynae/VVF camp". Here I gained a much better understanding of the sub-speciality and managed to assist in many operations especially VVF repairs, TVH and ureteric re-implantation. I also learnt about how to correctly diagnose the different types of fistulas, which was completely new.

5A annexe/acute gynae emergencies – I really enjoy working on this busy ward. I have gained great experience managing problems in early pregnancy especially ectopics and abortions and disorders in the puerperium. The variety of pathology is fascinating and patients are often extremely sick, so it can really be rewarding to watch them improve with appropriate treatment. I have become competent at basic skills such as evacuations but also developed surgical skills when managing ectopic pregnancies, pelvic abscesses and perforated uteri secondary to instrumented abortions.

Labour suite – This is my favourite ward; it is notorious as it is constantly overwhelmingly busy, with patients everywhere you can imagine and most of them are referrals from other units and so by nature very sick or complex. I have dealt with so many obstetric emergencies ranging from true shoulder dystocia, cord prolapse, APH, PPH, breech, multiple to eclamptics on the floor, these experiences will always remain with me and shape my future practice for the better.

Other work

Puerperal sepsis audit

This was the first project that I undertook; it was discussed in the morning meeting that puerperal sepsis seemed to be a very common problem causing a significant maternal mortality and morbidity, so we did an audit with some of the interns and SHOs in order to find out more. 25 patients had puerperal sepsis on one day, swabs were taken for MC&S and the patient's files were reviewed again 2 weeks later. 2 died, 7 needed further surgical procedures most for burst abdomen and over half were still inpatients 2 weeks later. Swabs revealed mostly nosocomial infections. The infection control team was involved, results were presented in the morning meeting and the Ministry for Health, my husband designed and made a mobile hand washing ward round trolley for 5B post natal ward, I managed to get the engineering department to fix all of taps on all of the wards, taught on correct hand washing procedures and put hand washing posters around the department.

Maternal death audit

This process previously happened in the department but had fizzled out. I started collecting the data again over three months and then presented it in the morning meeting. Further discussion after this led to re-initiation of the process departmentally. So now under the supervision of Dr Ononge we have weekly maternal death review after

the morning meeting on Thursdays, which is led by a different SHO each month. One of the key things that this has brought about is people actually talking about maternal death, what happened and asking questions when deaths occur. This brings accountability which is absolutely fundamental as well as many other wider impacts and changes.

National Maternal and Perinatal Death Review Committee

Presentation of my work on puerperal sepsis led to me being asked to join this committee. I have presented several times about Mulago outcomes/progress and audit in general. I have also actively contributed to the meetings, the national audit tools, the audit tool guidelines and attended a 3 day retreat where all crucial issues were discussed at length. I attended one training in Massindi district as "the obstetrician opinion" and taught about the process and on other issues that were highlighted as weak areas after death reviews had been done e.g. PPH.

Midwife Updates

Previously the midwives received no formal updates at all! I started these weekly trainings on Thursdays at 11am. The sessions alternate between the obs/gyn department and ward 14 in order to get the best attendance possible from labour ward staff. Recently the time has been changed to 2pm in order to improve attendance from ANC staff as they are too busy in the morning. We have taught on a variety of subjects including obstetric emergencies, infectious diseases, medical disorders in pregnancy and whatever else they wanted! Attendance varies between 10-40 with more when students are in the department and the wards are less busy. Snacks and drinks are provided and attendance is fed back to the head of department.

Teaching general

Initially I often taught in the midwifery and nursing school on a wide variety of conditions from skin conditions to obstetric emergencies. I really enjoyed this and was often very impressed by a number of students however, due to time constraints I only did this for a few months.

I often teach medical and midwifery students on the job and I also facilitate foreign students when they are in the department because often they need to be directed as to where things are and how/why the system works the way it does.

Protocols

There is currently a real drive to get protocols in the department. This was started several months ago; I have made guidelines on ABC management of critical patients, PPH, post operative recovery and started molar pregnancy. Mostly we adapt Ugandan/WHO/RCOG and other guidelines to a suitable level for Mulago, then discuss them with various specialists and present them in the morning meeting. I hope that by the end of the next year most guidelines will be done and accessible to all on the Mulago website.

Liverpool Mulago Partnership

This is an educational exchange founded by Dr A Weeks and started off this year; whereby twice a year 2 staff from Mulago and 2 from LWH visit the other institution for 2 to 4 weeks in order to fulfil specific learning objectives that cannot be met in the host institution. I have facilitated this process by mobilising staff, organising

meetings and presentations and helping visitors whilst they are in Mulago. The focus for the last LMP visit was post operative recovery and monitoring of patients. This focus was chosen due to several deaths due to inadequate monitoring and in order to lay the foundations of HDU principles, with the aim to create a HDU area as the focus for the next LMP.

Painting labour ward, installing curtains for privacy and creating post operative recovery area

Patients post op after emergency c-section in labour suite theatre were previously wheeled out of theatre and left in the corridor before being transferred to the post natal ward; there was no appropriate space for post or pre operative patients. As two of the small delivery rooms were not being used appropriately and there was no privacy for patients in the main delivery area, low risk side, we decided to do something about it, after discussion with senior staff. My friend raised some money through running a half marathon, we mobilised twenty friends to help us and we persuaded sadolin paints to give us a major discount on paint. We managed to

1. Create an appropriate post operative recovery room for labour suite theatre
2. Created a room dedicated for patients awaiting theatre
3. Equipped the post operative recovery room and mobilised the staff about the changes
4. Installed rails and curtains in the main delivery area to divide it into four sections
5. Painted the main delivery room, the corridor, the pre/post op/neonatal resuscitation and other smaller rooms

This task was certainly challenging, especially in such a busy delivery area, however it has made a definite improvement to the overall standard of labour ward for patients.

Mulago website

In order to improve the departmental visibility and profile, Dr Kagawa (specialist) and I have completely overhauled the entire content of the website. It previously was only one brief page hidden under the medical directorate page. Content now includes staff profiles, services offered, student affairs, photos etc. We plan to upload it onto both the hospital website and Makerere website and add the departmental protocols in the future.

Neonatal resuscitation training

I had noted throughout the year that skills in this vital area were lacking and the issue was raised again in the departmental meeting after a presentation of an audit by the interns on why babies die in SCBU. I really believed that this training had to be compulsory and for every single midwife that delivers/receives babies. So, we fund raised from the UK and mobilised the department. We got agreement and a formal letter from the head of department, head of SCBU and the nursing ward in charges saying that the training was compulsory. The sessions were led by two Mulago midwives, who had previously been trained as trainers of neonatal resuscitation and myself and Dr Alldred (the new EBF) as course facilitators. We carried out a six times one day training at the end of august for all of the midwives in delivery areas. The course ran extremely well; feedback and attendance were outstanding, far better than I had ever hoped for. We trained 103 staff and dispelled many myths. All were designated as competent at the skill according to American guidelines and due for repeat training/testing in six months or one year. We plan to continue these training for midwives regularly with the next 6 months from now; but also hope to train doctors and anaesthetic officers too.

Midwife of the month award and midwife empowerment initiative

Anneke Sikkema, a Belgian midwifery student who has previously spent a lot of time in Africa, conceptualised these ideas after spending time in the department. With the support of her friend Pastor Martin Ssempa we organised a big "midwife appreciation lunch" for the midwives; there were many speakers including the director of the hospital and we thanked and congratulated them on all the good work they do. Name badges were given to all staff in delivery areas and we launched the midwife of the month award. Each month the staff, including both doctors and midwives, fill in a nomination form to nominate the midwife they feel has performed the best that month, and she is given a certificate and a sum of money to reward her. Her photo is taken and is on the notice board for the duration of the month. The aim is to improve moral, motivation and good team working. So far this has been running successfully for several months and we plan to spread it to other wards too. This has also gained the department some good press on T.V, in several newspapers and radio reports, in a time when the vast majority of press regarding Mulago is often negative.

Health promotion work

Staff from the department has been involved in several health promotion activities throughout the year. I participated in a breast cancer awareness walk, which is how I met Dr Wanyama which led to my involvement with Ministry of Health work. There was a cervical cancer awareness walk where staff offered free screening to anyone that wanted it in the centre of Kampala. At another cervical cancer awareness initiative I spent several hours answering questions for a group of women on all sorts of things and then carried out cervical cancer screening. I also did a family planning talk to a women's group in Kampala.

Audit book

Throughout the year I have been working on a book with Dr A Weeks and Dr S Ononge entitled "Audit in Maternity Care; A Guide for Low Resource Settings" which has been accepted for publication by RCOG Press. This book is a practical guide of how to actually carry out audits practically. We plan to finalise it in the next few weeks.

Handing over

Dr Kate Alldred, the second fellow arrived at the beginning of august so we have been lucky to have a hand over period of all of the ongoing Eleanor Bradley projects, as well as facilitating the neonatal resuscitation course together. I wish her and all future fellows good luck and hope that they enjoy this wonderful experience as much as I have. I hope that this fellowship can serve as a model for many more fellowships in the future, so that British obs/gyn trainees can have a significant impact on improving maternal health throughout Africa and the developing world.