VOLUNTARY WORK AT QUEEN ELIZABETH CENTRAL HOSPITAL, BLANTYRE, MALAWI

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"Ukayenda, umaona agalu a michombo!" was the jovial advice I received in response to my obvious apprehension while converting a spinal to a GA without saturations or $ETCO_2$ monitoring. The translation of this local proverb is *"when you travel, you see dogs with navels"*, and indeed as I now write my account of the last ten months, I'm astounded by the number of things I have seen and experienced that I never thought possible.

My reasons behind embarking on a year in an African hospital included the desire to experience a developing world healthcare system, and to improve my clinical judgment and experience prior to pursuing registrar training in the UK. When considering possible destinations, my search criteria included a largely English-speaking, safe and stable country with good travel opportunities within and around the country. Malawi fitted the bill, with the additional benefit of firsthand positive feedback from anaesthetists who had spent time in the department at Queen Elizabeth Central Hospital. Contacting the Department of Anaesthesia almost seemed too easy – a Google search of "Anaesthesia Malawi" brought up the College of Medicine webpage with the head of department's email address. An email outlining my wishes to work in the department and a copy of my CV was met with a very positive response welcoming me to the department!

We began planning our year abroad approximately 10 months in advance – researching countries and hospitals, asking advice from senior consultants regarding career progression and applying for funding. Both the AAGBI and NIAA have been incredibly generous and greatly assisted in the significant financial commitment of volunteering for a year.

All too quickly, my CT2 year was finished and packing up our home and moving to Malawi was imminent. As we had suspected, things had fallen into place all too easily and a few weeks prior to our departure, national riots erupted in the normally peaceful Malawi due to political instability. With international reporting censored, we were unable to get a clear picture of the

danger the situation may present to us, but after communicating with our contacts in Malawi, we decided to proceed with our trip.

We were pleased to arrive in Malawi to a tropical climate, the clean and compact city of Blantyre and friendly and welcoming people. However, a major problem arose within hours of landing in the country when we discovered that the company my boyfriend, a civil engineer, was to work for had gone into liquidation. In contrast to his four weeks of unemployment and frustration at job hunting in a completely strange country and culture, I was welcomed into a very friendly anaesthetics department.

Queen Elizabeth Central Hospital is the largest hospital in Malawi with approximately 1000 beds and 1300 inpatients. The anaesthetics department staffs eleven theatres catering for most surgical specialties and also runs a four-bedded ITU for adult and paediatric patients. It consists of a German head of department, a Malawian deputy head, three medical anaesthetic trainees and 16 anaesthetic clinical officers.

Anaesthetic resources are basic, and frequently I was faced with equipment and drugs I had only read about in textbooks, such as draw-over vaporizers and halothane. ETTs and LMAs are reused and I quickly learnt the daily ritual of cleaning the used airway equipment in chlorine. Spinals (22-27G) are performed with heavy bupivacaine and/or heavy lidocaine. Analgesia is limited to paracetamol and diclofenac suppositories, pethidine and ketamine. Monitoring is varied, consisting of only a pulsoximeter in some theatres, while others had $ETCO_2$, ECG and NIBP. A small number of invasive pressure transducers had recently arrived and I performed the first intraoperative arterial line in my first month. Equipment and drug shortages were everyday events, be it oxygen, suction, water, swabs, ECG dots, bupivacaine…the list goes on! I was astonished how despite these conditions the department was remarkably lighthearted and unsurprisingly, good at improvising.

My experiences here will undoubtedly shape my future anaesthetic practice. I have learnt a great deal both professionally and personally and I would strongly recommend a year abroad to anyone. I have learnt to hone my clinical judgment, gained invaluable paediatric experience,

witnessed weird and wonderful pathology as well as astonishing limits of physiology I didn't think possible and I have learnt to work within a new culture. Not to mention, learning to "laugh like an African", drive a pick-up truck and being reminded of how to appreciate the most simple of pleasures. My Type A personality has certainly been down-graded with life in Africa!

The principal lesson I have learnt is how fortunate we are to have the NHS and just how safely anaesthesia is delivered in the UK. With the clinical expertise, availability of resources and staff and the infrastructure of the NHS it's no wonder that anaesthetic, and overall, morbidity and mortality in the UK is a fraction of what it is in the developing world. Working and living conditions in Malawi are incredibly tough. Healthcare workers frequently work 6 days a week, do 24 hour on-calls - often working several consecutively, and rarely take annual leave. When leave is taken this is mostly spent doing locums. Add to this the resource shortages at the hospital and their dismal salaries – not always paid on time, and the huge inflation driving up the cost of living. I wonder how many of us would tolerate such conditions for a few weeks, let alone years?

I have also gained real insight into just how much ODPs do at home. Working in an environment where I prepare all my own equipment, clean in between cases and at the end of the day and working solo, makes you truly grateful for the skillful help they provide us with. However, without anaesthetic rooms I did find that there is a greater understanding amongst the theatre and surgical staff of what we do as anaesthetists and it was not uncommon to ask the Professor of paediatric surgery to give cricoid pressure.

Clinically, the obstetrics experience in Malawi exposed me to most of the nightmare situations I could possibly imagine happening during an on-call at home. With my training in England being largely based on CSEs my confidence in spinals was wavering. A few weeks on a labour ward with 12,000 deliveries per annum and approximately 200 caesareans per month, where the only regional option is a spinal, and working with clinical officers able to site spinals into any patient with the greatest of ease, quickly restored my confidence.

Sadly, my experience on labour ward also exposed me to the sobering reality of the all too frequent poor maternal and neonatal outcomes endemic to the developing world. So many factors

contribute it is difficult to know where to begin. There are limited midwives, no CTG, poor antenatal care, high incidence of HIV, limited supplies of blood, antibiotics and bupivacaine, no labour analgesia, no recovery, poor prioritisation of cases and limited senior obstetric support. Not forgetting the strong cultural belief in natural healers and a prevalent fear of hospitals. Events that would be considered SUIs at home are at least a weekly event here and as a result I found labour ward a harrowing place.

My most positive experience has been doing paediatric anaesthetics, working with a skillful and dedicated paediatric surgeon. Having anaesthetised over 250 paediatric cases ranging upwards of 1.3kg newborns, my fear of little ones has been replaced with great enjoyment of paediatric anaesthesia. With the extensive paediatric case load, the clinical officers are very experienced in handling children and were able to support me in gaining great experience as well as helping me master the secrets of how to cannulate Afro-Caribbean children!

My greatest pleasure in Malawi has been getting to know its people. Despite the constant adversities, my Malawian colleagues are surprisingly cheerful, humble and resilient. Laughter is so inherent to them and they are always ready to smile. I hope that in return for my experiences and the warmth I have been shown, I have made a fair contribution to their department, both through fundraising for 15 pulsoximeters as well as my work in the department.

As simple as it sounds, I think my greatest contribution has been to lead the department in the organising of its storeroom. Decades of donations were lying unused and covered in dust and termite nests. By involving the clinical officers I hope it will establish a sustainable model to maintain order of future donations. Most importantly, they were able to see how much equipment was available and it has motivated the department to reuse less equipment – ETTs, LMAs and suction catheters are being replaced more frequently, weekly ventilator circuit and HMEF changes have been introduced and Ambubags were distributed to every ward of the hospital.

It has been a humbling experience living in a country where people queue for basic foodstuffs such as sugar and maize fertilizer and where there are chronic fuel shortages. My boyfriend's labourers, who are by no means the poorest of the population, do a day's work for less than half

the cost of a Costa coffee. The country has been living in the shadow of a corrupt president and while his death in April has bought hope to the country, we are beginning to see the harsh realities of the necessary steps required to rebuild international confidence in Malawi. We leave at a time when the currency has been devalued by 50% which will inevitably make the cost of living unmanageable for many. I hope that this beautiful country is as resilient as its people and it continues to be "The Warm Heart of Africa".