Good Shepherd Hospital/ COMDIS – HSD Swaziland Placement Report

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'You're going to Switzerland for six months? That will be interesting' said most people when my husband and I told them of our plans. After explaining that it was actually Swaziland 'a small landlocked country, about a third bigger than Yorkshire, to the top right of South Africa, next to Mozambique', the next questions usually focused on how challenging it would be working in a hospital in an African country with poverty and disease a feature of every day.

The African continent is widely misunderstood. It is often considered to be a dangerous, desperately poor, the 'dark continent', thanks in part to the way it is portrayed in Western media. The vastness and diversity of the continent and uniqueness of each individual country often seems to be beyond our understanding. Swaziland has similarities to other sub Saharan African countries in language and socio – demographic factors, however it also has a distinct culture and political landscape of its own.

Swaziland is an absolute monarchy and classified as lower middle – income with strong economic ties to South Africa. The country has very wide income inequalities with around 70% of the population living on less than $1.25 per day. These inequalities are very visible. Some areas of the urban centres of Mbabane and Manzini are noticeably wealthy and familiarly 'developed world', however just an hour down the road many people are living in rural poverty in traditional homesteads.

Arriving at Matsapha International Airport

As might be expected life expectancy is low at 50.5 years and infant mortality is high at 54 per 1,000 population[1]. Previous placement reports have detailed the ongoing health needs in Swaziland and the Lubombo region, so I won't repeat this here. Suffice to say TB continues to be a major challenge, particularly drug resistant TB, with high rates of

[1] CIA World Factbook (2014) https://www.cia.gov/library/publications/the-world-factbook/geos/wz.html

underdiagnosis and poor access to treatment and support. Rates of HIV remain among the highest in the world. There are wide gender inequalities and a very traditional patriarchal society, which compounds problems of gender -based violence and contributes to a higher prevalence of HIV in women. Other key health issues include diagnosis, treatment and management of non – communicable diseases such as diabetes, hypertension and cardiovascular disease.

My placement at Good Shepherd Hospital was challenging, but it was also interesting, exciting and fun. Swaziland is beautiful, warm and welcoming and I have gained a deeper understanding of both this small country and the wider continent. I can now tell others that while there is poverty, disease and inequality, there is also vibrant culture, stunning landscapes, wonderful people and a developing young, modern and educated population that is motivated to work to address the challenges this country faces.

Zebra cub in Mlilwane National Park

The Work

Three things became apparent during the week I had to handover with my predecessor, Clare:

1. Six months is a very short placement, particularly when many of the COMDIS projects have long timescales.
2. There was too much to do for just one person and I was very glad to have my husband, Liam, coming out to join me.
3. Tick – bite fever is unpleasant and wearing leggings while running to avoid this is a very good idea.

Clare valiantly struggled through a fever to handover three main COMDIS projects at various stages of development, as well as other priorities including infection control.

When Liam came out he was also tasked with evaluating operating theatre services with a view to suggesting improvements in management and quality assurance.

Handover between StRs

It occurred to me early on that the system for handing over between registrars on placement could be strengthened, improving continuity and increasing effectiveness.

One of the difficulties I came across was a lack of 'collective memory' for COMDIS in Swaziland. I inherited projects at the stage they were at when I arrived, and while Clare had given me a verbal history, each project was complex and had been several years in development. Because of this it quickly became apparent that I was having the same conversations with our partners in – country as my predecessors had and while they were very polite about it, this was very frustrating for them.

More information on culture and working practices would have been helpful and meant less time acclimatising to working in a different country. In addition there should be clear direction on the sticky issue of giving money to people when they ask, as happens relatively frequently. Our colleagues working in local NGOs felt that giving money directly to people was detrimental to the sustainable development they were trying to achieve and that paying school fees or offering money in return for work is more beneficial in the long term than handouts.

To address these issues I developed a handover/ orientation file on the shared dropbox which contained narrative summaries of each project, detailing timelines and key decisions or meetings held. I also created a contact directory, started developing cultural notes and instructions for budget management and handover. In addition I implemented a system of regular briefings for partners on project progress, including a briefing when I left that introduced my successor.

Finally, we were very pleased to recruit a research officer to the COMDIS team, following a competitive recruitment process. Bongekile started just a month before we left and had to take in a lot very quickly, particularly as there was six-week gap between my successor and me. The addition of Bongekile to the team will prove invaluable in improving continuity and increasing effectiveness.

In addition to this a longer handover period between StRs or staggered placements with substantial crossover would help to strengthen the project, build better relationships with partners and make COMDIS Swaziland more effective.

Voluntary Male Medical Circumcision Project

Clare's report describes the development of the voluntary male circumcision service. Our role was monitoring the progress of the service and gathering information for evaluation purposes as well as some direct day-to-day management. The main priorities were to get the hospital to take over management of the clinic and develop strategies for promoting uptake.

Early evaluation results indicated that uptake of male circumcision at the GSH clinic was low. Different strategies were discussed to promote uptake, including examining the barriers to early infant male circumcision. The outcome of these discussions was the development of a small project under the existing proposal to improve uptake in infants by gaining consent for the procedure during the antenatal period rather than immediately after birth. This was an excellent opportunity for the new research officer to develop a study proposal for a small discrete project.

Development of a Regional MDR TB Service

When I arrived in Swaziland the development of an MDR TB treatment service for Lubombo region was a priority and there was a drive to move it forward both locally and nationally. Historically MDR - TB patients had been referred to the National TB Hospital on the outskirts of Manzini (a minimum of 70km away) for treatment. We also knew from previous surveys and local and international evidence that a large number of cases go undetected.

This was a large and complex project involving many stakeholders. The Lubombo region is large and predominantly rural, with a population of almost 250,000 people, many of whom live relatively far from their nearest health centre. Given the intensive nature of treatment for drug resistant TB this offered some very interesting challenges.

My role was to support the development of a service, which addressed the needs of people in the region. To do this I had to work closely with the Ministry of Health, partner NGOs, regional leaders and the hospital.

The new service had no extra resources allocated to it, other than the small budget from COMDIS for operational expenses. I worked closely with the TB team at the hospital to identify local priorities and challenges and develop a model of care that addressed these within existing resources. We also identified the minimum level of ongoing support required from the national team that would ensure the new service was robust and sustainable.

I worked closely with stakeholders within the hospital including the senior management team, clinicians and nursing staff to ensure that they were involved in the development of the service. Initially there was a lot of resistance, particularly from the outpatients department and radiography. Concerns were mostly about inadequacies of TB infection control.

In the absence of a functioning hospital infection control team I worked closely with the national TB programme infection control lead to develop both short and long term strategies for TB infection control throughout the hospital. The short-term strategies were developed in partnership with all stakeholders and were written into a hospital TB infection control policy and signed up to by all partners. In the longer term COMDIS will work with the national infection control team to produce a comprehensive assessment of infection control needs and a put together a funding proposal to obtain the resources to improve this.

Other key challenges included:

- Ensuring that the risk of losses to follow up was minimised by working closely with regional clinics to establish a model of care for daily injections.
- Establishing a model of treatment support appropriate to the resources available and the widely dispersed, rural population we were serving, including the reallocation of some COMDIS funds to recruit extra treatment supporters.
- Developing a home assessment team from existing staff resources whose role it is to conduct home infection control assessments, contact tracing and psychosocial assessments.

- Persuading both the hospital TB team and the national TB programme not to start the service until we had buy - in from all stakeholders and all safeguards were in place to ensure losses to follow up were minimised and treatment adherence maximised.

I developed local guidelines outlining diagnosis and treatment pathways, roles and responsibilities of all stakeholders, and procedures for review, monitoring and evaluation. This was written in partnership with stakeholders and designed to be a simple operational guideline that clearly described how the service works. In addition to this pathways are now being developed for use in clinical areas.

Setting up a new service in a resource limited setting provided many interesting challenges and a lot of learning. It was an excellent opportunity to put into practice leadership, influencing, negotiation and management skills in an entirely different setting.

Entrance to the TB Clinic

Non – Communicable Disease Decentralisation Project

The burden of non – communicable diseases such as diabetes, hypertension and cardiovascular disease is increasing in Swaziland. The aim of this project is to develop an integrated, comprehensive, decentralised non-communicable disease service for Lubombo. Currently, NCD care is provided using a centralized model, with the majority of care provided by hospitals. Hospital services are working at full capacity, with little room for expansion. With the increasing burden on hospital resources, this model of care is no longer sustainable.

In order to respond to the needs of the population in terms of NCD health service delivery, the Ministry of Health established the National NCD programme. A Swaziland NCD strategy is being developed and aims to address morbidity and premature mortality caused by NCDs. One of the recommendations of the strategy is the development and implementation of a comprehensive integrated NCD service in the community.

When I arrived this project had already faced many delays and the priority was to attempt to move it forward. I achieved this through:

1. Identifying and building relationships with national networks in order to get the project approved.

2. Developing local resources for the pilot.

There was a need to identify national stakeholders within the Ministry of Health and other national NGOs so we could get support for the project. A key issue was getting agreement that we could procure NCD drugs for pilot patients, both at the hospital and at rural clinics and decide on a nationally approved distribution method for this. This was complicated by GSH being a non - government hospital and needing to charge for drugs.

I approached the National NCD Decentralisation committee with our proposal. Working closely with this committee was a priority, as having national support would help to ensure the success of the pilot. As they had yet to start any decentralisation plans it also meant that the results of the COMDIS pilot would feed directly into the national programme.

When developing and adapting resources for this project it was important to keep the patient at the forefront. With this in mind we worked closely with hospital staff to ensure that the information in the clinic desk guides was appropriate and would be understood by patients. It was also important to ensure that the need for patients to be able to make choices about lifestyle behaviours was understood by staff in the clinic and that patient interventions supported this.

We developed an information leaflet on healthy lifestyles for patients, based on an earlier draft. This was piloted with members of the local population to ensure that the language used was appropriate and the messages about healthy living were clear. We also redesigned the NCD clinic register in consultation with clinic staff so that it could function both as a complete patient record and a data collection tool for the study.

Infection Control

Improving infection control across the hospital was a key priority. I was aware that there had previous outbreaks in the hospital including neonatal sepsis and TB among staff. Given the development of a new drug resistant TB service based at the hospital it was essential that infection control leadership, management and processes were strengthened.

The first step was to meet with the infection control lead to establish what his priorities were and how he managed infection control. Alongside this I talked to other members of the clinical team and observed infection control practice in clinical areas. I also reviewed previous outbreak reports, meeting minutes and recommendations to establish what was still in place following these incidents.

From this I was able to scope the scale of the issue and identify key issues to be addressed. I also reviewed the literature to identify how to do this in a resource poor setting.

It quickly became apparent that leadership on infection control was absent and that most members of staff felt that there were no nosocomial infections. I realised that there was a need to develop a long-term strategy, which looked at both diagnosis and surveillance of infections as well as building capacity and leadership. I also realised I didn't have the capacity to lead on this long term and a more sustainable approach was required.

In order to start addressing this I did the following:

1. Identified an appropriate senior infection control lead in the UK who I hoped would provide long-term mentorship and oversight to the IPC team.

2. Developed simple clinical definitions of common nosocomial infections in the absence of sufficient lab capacity.

3. Worked with the infection control lead and committee to identify key areas they required teaching on.

4. Delivered a teaching session on basic principles of IPC, the role of an IPC committee and surveillance.

5. Supported the committee to start developing a long-term plan for infection control surveillance and management. This included ensuring there were representatives from each clinical area on the committee, discussing how to start a surveillance system and what to do in response to an increase in infections. We also discussed the need for clinical leadership and identifying areas for teaching and development in different areas as well as simple interventions such as e.g. Catheter care packs.

This work should be picked up by my successor. The ongoing Ebola epidemic in West Africa, while a very long way from Swaziland, has brought this into sharp focus.

TB Infection Control

In order to improve TB infection control I worked alongside clinicians, nursing staff and the hospital senior management team to build on work of predecessors and produce a comprehensive TB infection control policy. This was particularly important and timely given the development of a new MDR - TB treatment service and the concerns expressed by staff about the risk this presented to them and patients and visitors to the hospital.

One of the main challenges was adapting evidence and guidelines on best practice in TB infection control to local infrastructure and limited resources. Part of my role was to identify where the gaps were in administrative, environmental and PPE infection control measures and attempt to address these through policy, training and the development of a proposal to secure funds for improvements.

To develop the policy I reviewed guidelines from WHO and conducted a brief evidence review on how to adapt these in low income settings. I also worked closely with the hospital TB team, other key stakeholders within the hospital and the regional TB infection control lead.

The TB infection control policy emphasizes the need to have appropriate IPC plans with named leads in place in each area of the hospital. The policy also encourages leadership from senior members of staff and provides reassurance that the protection of staff is of highest priority.

The policy was written in simple language so that it would be accessible to all hospital staff, although it is recognised that some ancillary staff may have difficulties with this and a future piece of work would be adapting this to a simpler version in Siswati.

The implementation of the policy is an ongoing process. The dissemination of the final draft was planned to coincide with the new MDR TB service and TB infection control training led by the National TB Control Programme. The policy includes a quarterly reporting tool (developed by Clare and James) which should be completed by each department and returned to the infection control committee, however as described above this committee needs support to develop further before this process becomes embedded.

Medical Student Supervision

Many medical students come out on elective and they often ask to do public health projects. I supervised a variety of projects that directly related to the work above, which was very helpful given our limited capacity.

Other work

Liam spent a lot of time in theatres, evaluating current systems and developing recommendations for quality improvement that were shared with the hospital management team. Recommendations included those on improving infection control, safer practices and more efficient processes.

One of the operating theatres at Good Shepherd Hospital

Summary

This was a fantastic and unique opportunity and I want to thank both the Johns for supporting us. Six months is a very short placement and while I was happy to see friends, family and the dog in some ways it felt like I was just starting to make progress when I left. I returned having had an amazing experience, made some good friends and some great travelling experiences in Swaziland, South Africa and Mozambique while also hopefully having had a positive impact, even in some very small way, to the health of the local population.

The Bushfire Festival (held in May each year) was a highlight.

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