

REPORT TO COUNCIL
INTEREST TANZANIAN PROJECT

OCTOBER 2016

BACKGROUND

The IAES was approached via INTEREST, with a request for support and teaching in Bugando Medical Centre, Mwanza, Tanzania by the Director, Dr. Alphonse Chandika. This occurred as an ex Adelaide Anaesthetist, Dr. Derrick Selby was currently working in Mwanza providing a humanitarian service. He had knowledge of the INTEREST program provided in Malaysia and discussed an opportunity with Dr. Chandika.

The hospital and administration were very enthusiastic for our participation and clearly had contacts from other countries and disciplines and saw INTEREST as adding to their progressive teaching and development plans.

Whereas the Malaysian model required the requesting country or facility to provide accommodation for the visitors, it became very clear at an early stage that the hospital simply did not have the financial resources to allow for this. The visitors then undertook to cover their own expenses.

This was a new program and in part was a scoping exercise to determine the capability and needs of the hospital and surgical staff with a view to providing a long term support. In time this may well be in conjunction with BSI akin to the Malaysian proposal.

The proposal was not to complete a large surgical workload, but rather to work with and support the local staff with a view to education, encouragement and an increase in skill levels, with minimal disruption to their daily duties and commitments.

This was achieved by involvement in ward rounds, theatre sessions and lectures. The content was at the direction and request of the local surgeons in a support capacity rather than a hierarchical capacity. It became clear however that the hospital resources and facilities would significantly alter our plans.

The IAES participants were Prof. Dimitrios Linos and Assoc. Prof. Rob Parkyn. We arrived around October 21 and departed October 29. During the week surgical demonstration operations were performed, lectures provided and a practical Surgical US course provided.

BUGANDO MEDICAL CENTRE

Bugando Medical Centre is a consultant and teaching Hospital for the Lake and Western zones of the United Republic of Tanzania. It is situated along the shores of Lake Victoria in Mwanza City. It has 900 beds and over 900 employees. It is a referral centre for tertiary specialist care for six regions namely: - Mwanza, Mara, Kagera, Shinyanga, Tabora and Kigoma. It serves a catchment's population of approximately 17 million people.

The Catholic Church built the Hospital between 1968 - 1977. In 1972 the Hospital was nationalized by the Government. However, in October 1985 the Government handed back the Hospital to the Tanzania Episcopal Conference of the Catholic Bishops of Tanzania who is the owner with an agreement that the hospital be run in partnership with the government to provide Government Services as a referral and consultant hospital for the Lake Zone.

Their stated Vision:

“To be a consultant centre of excellence in health care provision, research and teaching, inspired by the love and compassion of God.

Our Mission:

Bugando Medical Centre is a referral hospital under Government and Church Partnership, which exists to provide tertiary specialist quality health care, consultancy, research and training in health.

Values

- We are committed stewards entrusted to serve all people with integrity, compassion and love.
- We are a non-profit making health institution committed to provide health services that are affordable and accessible to all.
- We protect and provide for the dignity of human life. We serve all people irrespective of religious, tribal, social standing or political background.
- We are committed to zero tolerance to theft and corruption.”

In practice though the facility was significantly under resourced and there has been little ongoing maintenance. There seemed to account for a lack of forward planning and actions were somewhat reactive rather than proactive and limited by the lack of resources and funding. There are improvements happening however with a new and impressive oncology centre.

The theatres were basic and the equipment rudimentary and apparently they can become oppressively hot though we were fortunate with the weather. There are large numbers of staff, residents and students in theatre particularly during demonstrations. Single use materials such as pencil diathermy were repeatedly reused until no longer functioning, with frustrations in theatre at times to finally get something that was reliable. Electrical safety was an issue with broken open power points and no evidence of any safety leakage devices. Overhead lights with 12 globes had only 4 or 5 functioning. A headlight would have been very handy even the cheaper versions of an LED camping headlight. Surgical scrub gear including tops, pants, shoe covers, hats and masks were to be provided personally by each individual and that includes visitors.

What was impressive however was that in theatre a formal Check list was performed along the lines of “correct patient, side and operation”. The walls were decorated with guidelines for emergency situations such as a failed intubation as most anaesthetics were provided by the nursing staff under general guidance.

Although our principal interest was obviously endocrine surgery, clearly we were exposed to a great array of diseases, particularly breast cancer. There is an apparent high BRCA1/2 incidence with mostly triple negative breast cancers. It would not be possible to not have some role as a general surgeon whilst visiting.

In terms of outpatients, the numbers were clearly overwhelming. The lack of readily available tests such as US or CT scans, let alone cytology made a diagnosis rather rudimentary. There seemed to be minimal patient discussion and most consultations were in a very crowded, noisy small room of perhaps 3 to 4 minutes duration. If surgery was advised the patient was

informed of their “Malipo” or required co-payment which had to be paid prior to surgery. The amount was nominal but often out of the reach of the patient and their families. Hence on the day of surgery it was common to find that the patient was cancelled as the Malipo had not been paid. This clearly disrupted the theatre throughput.

It was not clear as to the outcome of the various surgical patients and procedures. There certainly was no apparent follow-up in the outpatient sessions attended by the visitors. It was not clear what the infection or complication rate was.

I was impressed regarding the commitment and dedication of the Medical and Nursing Staff. This was probably related to their strong religious background and indeed several of the female medical staff were nuns. Dr. Washington was head of the surgical department and was a skilled, conscientious and dedicated surgeon. I noted that his younger colleagues by enlarge has similar enthusiasm. This does auger well for the future of the hospital and medical system.

Unfortunately as we arrived, Dr. Chandika was just about to transfer to a new posting as Acting Director in Dodoma, the capital of Tanzania. It sounded like this hospital would be more adequately resourced. This may have an impact on any future commitment by the IAES. We did also meet with Prof. Kien Mteta, a urologist, Director General of Bugando and very welcoming and supportive. Similarly Prof. Linos met with the Dean of the University and plans were made for Prof. Linos to donate a supply of surgical textbooks.

Safety Issues for Visitors.

Personal safety needs to be strongly considered, but not dissimilar to any high population area or city and particularly in Africa. We were very strongly advised not to leave the secured hotel compound at night and absolutely not on foot or alone. It was reassuring to have guards on each floor of our hotel.

It was also imperative to establish a reliable, recognisable and English speaking driver from the outset. It was not unknown for a random taxi to end up in a high jacking and demands for ATM depletion by interested parties. Fortunately we were lucky to have the immediate guidance and advice from western colleagues, namely Dr's Derrick and Susan Selby initially from Adelaide who provided great comfort! They allowed us to use their driver and provided early practical advice. This local knowledge is essential for any trip to Africa.

The prevalence rate for HIV in Tanzania is around 5% but as Mwanza is a port city on Lake Victoria and a transport hub the local incidence of HIV is thought to be much higher. But HIV is not discussed and rarely disclosed. The resident staff may at times indicate that the patient as a “client of CID (Clinical infectious diseases)” or you may notice that the patient is taking anti-viral medication. Essentially visitors should regard all patients as being potentially HIV positive. Hence needle stick injuries are of great concern and in future a more detailed response to any injury needs to be put in place. There was a USA backed facility nearby which would have been our first point of contact but this issue needs definitely to be formalised before any future visits. Similarly TB is an issue and I expect we were exposed to positive active cases. This raises the question of taking your own N95 mask or similar. Malaria is a risk and Malarone or tetracyclines advised starting before arrival and completing after departure. Dengue fever is a real concern and protection, especially at dusk, from mosquitos is essential.

Personal hygiene is essential and the use of alcohol hand sanitizers are important to be used regularly through the day and certainly before any food intake. And note that in the hospital it was not uncommon at meal breaks that once staff had washed and cleaned, that shaking hands was not encouraged but rather touching of the forearm at most. Most visitors do have some gastrointestinal disturbance of variable severity and a personal medical pack, antibiotics and Zofran wafers is advisable. Comprehensive insurance is mandatory.

THE FUTURE

The experience was extremely rewarding but at times quite confronting. These visits should not be viewed as “medical tourism”. They are not for the feint hearted. Travelling alone to Africa can be intimidating and wearing. Not the least the 20 hours flying time from Australia or less from Europe but with the inevitable further 20 hours waiting in hot, steamy and crowded airports waiting for unreliable connections.

I was heartened by the enthusiasm and dedication of the medical staff and their “sponge like” approach to learning. But I would describe the process as one step forward and one back.

I had anticipated discussing and teaching parathyroid disease at least. But these procedures were not done, simply because the ability for the general population to have a calcium estimation was non-existent for most and the diagnosis not apparent. The Ultrasound course and teaching was well received and I think probably the best thing we could undertake in terms of uplifting their service and diagnosis. But the chance of them actually getting even a portable US machine at this point in time seems unlikely. I borrowed a paediatric Sonosite for the teaching but this had a very limited probe and although the residents and surgeons were very quick on the uptake they admitted that they would not be able to access any US in the future.

Prof. Linos explored the possibility of Laparoscopic surgery but although a “Tower” may have been available I found out later that there were no functioning cameras.

Adrenal Surgery would not be worth considering at this stage as a balanced workup and diagnosis would be very difficult biochemically.

Thyroid surgery is in demand and teaching of appropriate surgical skills probably would be the mainstay for any future visit and preferably combined with ongoing US programs. The ability to take a portable US, even second hand would be of great value and perhaps this is worth discussing with various departments in the “West” regarding discarding superseded but functional equipment. If the facilities in Dodoma were more comprehensive then it would be worth exploring this site in the future also.

But perhaps one reason for considering a further visit would be simply to demonstrate support, solidarity and an interest in their program. I know they appreciated that. It was a pleasure to take on this trip and an honour to represent the IAES. The IAES can only benefit in the future with potential new memberships from the African community. I sincerely thank Prof. Dimitrios Linos for his participation and good camaraderie.

Yours Sincerely,

Rob Parkyn



