Clare Humphreys' Good Shepherd Hospital Placement Report

I arrived at Good Shepherd Hospital under the cover of darkness, but I did notice the rather ominous sign for Crucifix Funeral Directors and then a sign for coffins shortly before arriving at the hospital! Fortunately it looked less foreboding in daylight. It was not possible to have a handover at Good Shepherd Hospital, but I had the next best thing, a handover in Browns restaurant, Oxford. It did mean that some of the practicalities of working at the hospital escaped me at first. It was a while before I realised that the eye clinic was not the mortuary building but was in its own pristine and well equipped clinic at the bottom Good Shepherd Hospital site. It was even longer before I discovered the second tuck shop, housed in a caravan, by the entrance; an important find when you are living on site.

My predecessors have written extensive background information on health in Swaziland so I will keep it brief. Sadly HIV and TB rates are still extremely high. Swaziland has the highest prevalence of HIV (26% in adults) and the highest incidence of TB (1349 per 100,000) in the world. MDR TB is a growing problem. Obesity is a future epidemic in waiting. Swaziland has the third highest obesity rates in Africa, 6% of men and 37% of women over 20 are obese. Diabetes and hypertension, like other non-communicable diseases, are common and often remain undiagnosed. There are gender and wealth inequalities. Although there are some rich Swazis and probably a growing middle class, many Swazis live in poverty (the UN reports that 41% of the population are living below the poverty line, but it has been reported elsewhere as being as high as 70%). Primary education is free but secondary education is not. Swaziland remains the last absolute monarchy in Africa. King Mswati III reigns over a population of almost 1.4M.

Figure 1 King Mswati III greets the dancers at the 2013 Umhlanga (Reed Dance)

I was based at Good Shepherd Hospital for six months. I describe below some of the work I got involved in whilst on placement at Good Shepherd Hospital.

Setting up a Voluntary Male Medical Circumcision Service

Voluntary Male Medical Circumcision is recognised by the WHO as one of a number of key interventions in HIV prevention programmes in countries with low circumcision rates and generalised HIV epidemics. Swaziland is one such country and an ideal candidate for a national Voluntary Medical Male Circumcision programme. The national campaign "Soka Uncobe", "Circumcise and Conquer", was started in Swaziland in 2010 with the ambitious target of circumcising 80% of men aged 15-49 in a year. Unsurprisingly, this target has still not been reached. Around 20% (32,000) of the target population are reported to have been circumcised after an extended period of the campaign. Population Services International (an NGO working in Swaziland) have continued to promote and coordinate Voluntary Medical Male Circumcision across the country. Whilst the model of delivery was once standalone clinics and community outreach it has now moved to a mixed model of standalone clinics, community outreach and integrated hospital services.

One of my predecessors, Merav Kliner, had done extensive preparatory work in establishing Good Shepherd Hospital as a centre for Voluntary Medical Male Circumcision. Unfortunately the COMDIS proposal hinged on the building of a clinic on the hospital site, and this did not get underway until a year after it was originally proposed. In July 2013, what is locally known as a "CiB" or "Clinic in a box" was constructed in just one week. After all the waiting, things started to move quickly with Good Shepherd Hospital nurses and doctors being sent for training and FLAS (Family Life Association of Swaziland) starting one of their "Back to School" campaigns from Good Shepherd Hospital. This involved Population Services International undertaking community awareness and recruiting boys for the operation with their and their parents/guardians' consent. After this campaign, Good Shepherd Hospital took over running the clinic and developing an integrated service in the hospital.

I arrived just at the right time to help oversee the development of the service. In particular, how the clinic was to be run, who would staff it, how clients would be recruited, ensuring staff were trained, setting up data recording and monitoring and evaluation. There had been a few national developments since the original proposal. For example, early infant male circumcisions (infants under 8 weeks) were included in this service but the support and reporting lines, although still through Population Services International, appeared to be separate from adults(over 10 years old). I set up a working group including a focal nurse and lead clinician to oversee the development of the Good Shepherd Hospital. Our aim was to get the service embedded in hospital services, and for Voluntary Medical Male Circumcision to be offered routinely to any eligible male visiting the hospital, much as voluntary counselling and testing for HIV is. This seemed simple enough but there was quite a lot of scepticism in the hospital about the benefits of male circumcision, including among the more senior members of staff. Although we had a service delivery plan and staff had been trained in early infant male circumcision and adult male circumcision it was difficult to get them released from their current work to go to work in the clinic, resulting in an inefficient service. It also was a struggle, at first, to get it actively promoted in the hospital.

In order for the service to be successfully integrated, the hospital needed to feel they have ownership of it and also believe in the benefits of the service. This is where I had to use skills in public health such as leadership and persuasion. It also helped to understand the local culture and politics within the hospital, which I had to admit, was not immediately clear to me on arrival. A key factor in getting the hospital on board was to understand the reservations of various members of the hospital team. These included a feeling that the service was being imposed by external NGOs, the lack of resources in the hospital to staff it and scepticism about the evidence. It also involved working with local champions which included the focal nurse and lead clinician as well as others in the programmes team to advocate the service to others. Together we ran awareness sessions for all nurses and counsellors. I also ran a training session for doctors on the epidemiological evidence base for male circumcision as part of an HIV prevention strategy. This helped to unpick the myths surrounding voluntary medical male circumcision and to give clinicians the opportunity to air their views and address any questions. All these factors helped to change the tide of opinion in the hospital, and later on the management team agreed to fund a nursing assistant to be dedicated to male circumcision who can oversee recruitment, counselling, booking, the running of the clinic, aftercare, and record keeping. This should greatly assist the service to develop further in the hospital. My work also involved mentorship of the early infant male circumcision motivator who had been recruited by Population Services International but was not line managed by anyone. She is enthusiastic member of the team and I could see that the scope of her job could be extended.

There are also plans to work through the clinics Good Shepherd Hospital supervisors to recruit more clients and Good Shepherd Hospital is currently working with Family Life Association Swaziland, who are undertaking demand creation in the community particularly focusing on school aged clients. There is currently a national review of voluntary medical male circumcision services underway to inform a new male circumcision strategy for Swaziland. The work at Good Shepherd Hospital is informing this. It is a service that continues to develop and improve under my successors Helen McAuslane and Liam Keown.

Figure 2 Male Circumcision Clinic in a Box during the Back to School Campaign

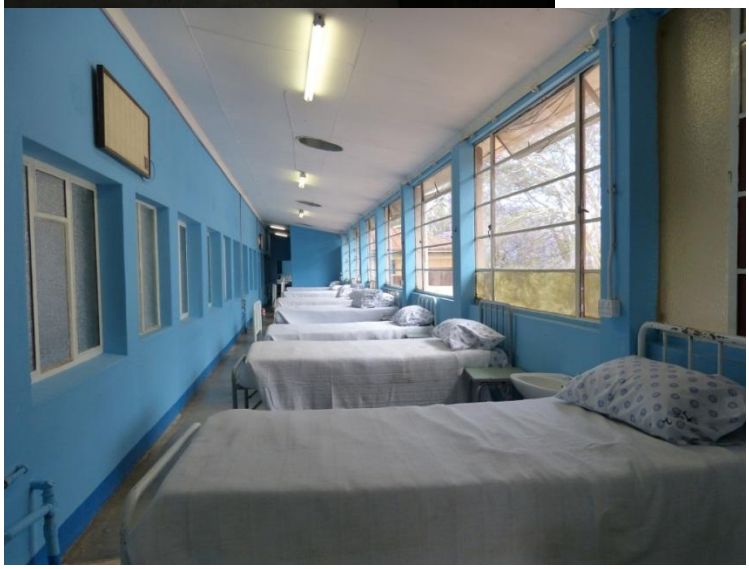
TB ward renovation

My predecessor, James Elston, managed to secure funding for a much needed TB ward renovation, the previous wards being not fit for purpose and a health hazard for staff and patients due to inadequate ventilation and isolation measures. He had worked with designers and architects back in the UK to come up with an innovative design within a limited budget. Work had started before he left, but when I arrived developments seemed to have stalled. They had stopped admitting TB patients as they were renovating both male and female wards simultaneously. This had not been part of the original plan, as the hospital could no longer admit TB patients, a situation which is far from ideal in a country with has the highest incidence of TB in the world. My aim was to get the TB ward up and running as soon as possible with improved infection control measures in place, but, much to my frustration, progress was slower than it should have been. There were times I wished I had swapped my public health training for plumbing as, in this instance; it would have been more useful!

These difficulties demonstrated the importance of having clear reporting lines and the right membership of the committee overseeing the project. The TB ward opened in October, much to the relief of many in the hospital. In retrospect I learnt a lot from this project. Good Shepherd Hospital is very hierarchical like many hospitals, an early understanding of this may have helped progress, but there did seem to be an active reluctance by some in management to open the ward despite the best efforts of the head of maintenance, finance and myself. I learnt much about management styles and methods of persuasion. It appeared that, in the end, it was external pressure from donors that got things moving.

Figure 3 TB ward renovation

Female TB isolation ward 15.7.13



Female TB isolation ward 14.10.13 finally ready for patients.

Laying the foundations for MDR TB treatment and initiation and follow up at Good Shepherd Hospital

James had started initial talks with the National TB prevention programme and University Research Council (NGO linked with Columbia University, USA) about setting up a much needed Multi Drug Resistant TB centre in the Lubombo region, with the intention of Good Shepherd Hospital hosting this. Currently Lubombo is the only region in Swaziland that has no MDR TB treatment initiation so patients who are diagnosed as Rifampicin resistant by Gene Xpert are referred to the National MDR

TB Hospital in Manzini for further investigation, treatment initiation, possible admission and further management. Unfortunately there is no follow up from Good Shepherd Hospital for these patients and it is thought that many do not turn up at the hospital, therefore jeopardising any potential recovery and putting their contacts at risk. My role was to resurrect these discussions and persuade management that it is a good idea for Good Shepherd Hospital to start offering at least outpatient MDR TB services. With some persuasive arguments about the benefits for the people of the Lubombo region and for the reputation of Good Shepherd Hospital, the tide had turned and there was a general acknowledgement by both our colleagues at the National TB prevention programme and management at Good Shepherd Hospital that we should start initiating uncomplicated MDR TB patients and follow up MDR patients through working with the newly appointed regional MDR TB team. This is a much needed and exciting development. Good Shepherd Hospital had the site assessment visit at the end of November and all TB staff have been trained or are currently being trained in MDR TB treatment and follow up. There are a few adjustments that need to be made before the service starts, but it is likely to start early in the new year. I started investigating the practicalities of treating and following up MDR TB patients in Good Shepherd Hospital, unfortunately timings were such that I had to leave Swaziland before the new MDR TB service started.

Infection Control

Given more time I would have liked to have done more work on infection control in the hospital, particularly broadening the remit of the infection control team. There is certainly a lot that needs to be done in this area. I updated the Hospital TB infection Control Policy in the light of the reopening of the newly refurbished TB ward and initiating treatment for MDR TB patients in the near future. This included introducing a number of infection control measures across the hospital including screening visitors of TB inpatients, which I tried to initiate with the support of the TB team but it needed further mandate from the clinical management team. I also helped organise a handwashing campaign in the Good Shepherd Hospital.

Figure 4 **Good Shepherd Hospital handwashing campaign day**

COMDIS projects

When I arrived there were four COMDIS research projects on the go. Two of these were at the proposal writing stage, one was near completion and one just about to start. Merav Kliner has recently been successful in getting the TB contract tracing project published. My role in this project was to undertake the data collection and analysis for the fourth model in the series and disseminate the results among the TB team.

The male circumcision study commenced in September and is now nearing the end of the research phase. The proposal had been overtaken by developments nationally but I have investigated many alternative ways of undertaking the study and getting comparative data. The MDR TB study proposal was updated in the light of national and regional developments and I got this proposal successfully approved.

One of the new studies, which had been in the pipeline for a while, was to introduce a decentralised community clinic service for non communicable disease. This proposed study is going to examine treatment outcomes in hypertension, CVD and diabetes patients having routine follow up in the community clinics compared to the hospital. This proposal went through lots of iterations and has finally been approved. It was a challenge to balance achieving a rigorous study design with the practicalities of how it could be delivered on the ground. Approval was needed by many stakeholders to change the system of delivering NCDs health care in clinics. I spent a lot of time updating the desk guides (practical handbooks for treating non communicable diseases in the community), the proposals and speaking to staff at Good Shepherd Hospital and outside on how to improve the delivery of the service in the hospital. Sister Sweetness was doing her best to get things moving but, unfortunately, demands from other parts of the hospital meant that it was difficult to get dedicated staff to the service and implement changes. Now that the new hospital management board is in place and NCDs are being managed under programmes rather than the clinical team, decisions are likely to be made to move things forward quickly. However, extra resources are required to get the project underway, as highlighted in the proposal.

Supervising colleagues

It was great to get the opportunity to supervise two medical students on their elective to undertake some public health work. They devised a pre ART audit. I also got the opportunity to mentor other members of staff in the development of Voluntary Medical Male Circumcision programme including the nursing assistant and early infant male circumcision motivator. This is something which I think is important for the registrar on placement with Good Shepherd Hospital to try and build capacity in the hospital and make the work undertaken there more sustainable.

Other projects

As the only public health member of staff in the hospital you often get called upon to help with different pieces work. For example, I helped write a bid application for a community clinic to get funding from the Ministry of Health, investigated options for an electronic patient record management system, did an assessment of the Good Shepherd Hospital laboratory to assess capacity and equipment, helped in the early stages of setting up a Swaziland Snakebite Authority, as

well as being on hand to answer people's questions! I also set up the placements for my successors, Helen and Liam with the COMDIS team in Leeds.

Whilst my placement at Good Shepherd Hospital had its challenges. I am really grateful to have been given the opportunity to work in this setting. Due to the steady stream of registrars we have had here over the years there was a lot of ongoing work to finish off and continue. In future I would like to set up, design and carry through my own projects. I have certainly met and worked with some interesting people; travelled the country; met/seen from a distance the King twice; was in southern Africa when the great Madiba passed on; got lost in the lion enclosure trying to find my way out of Hlane at night, visited the southern most tip of Africa; was interviewed on local Swazi TV; hold the record for the most number of capsizes whilst white water rafting in the Zambezi river and had (and recovered from) a tropical disease.

It was a privilege to work at Good Shepherd Hospital and certainly an experience I will not forget. I would like to thank my work colleagues for their support both at Good Shepherd Hospital, COMDIS-HSD, University of Leeds and Bradford Teaching Hospital Foundation Trust, and the friends I made in Siteki for making my time enjoyable. I would also like to thank the medical elective students for the great trips and volunteer doctors for their friendship and visa advice! I got to explore a bit of Southern Africa and it is certainly a place I hope to return to in the not too distant future.

Sala Kahle!

4.2.14