Running a paediatric, neonatal and maternity wards in a humanitarian context, Aweil, South Sudan

Jun 24, 2016 | 0

| General medicine,o&g,ontheblogs,onthejobs,paediatrics

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Jordan Amor-Robertson is a paediatric trainee. She completed her basic training at the Royal Darwin Hospital and Princess Margaret Hospital in Perth. After passing her exams in 2014 she gained overseas experience with a small NGO in Panama before joining MŽdecins Sans Fronti÷res/Doctors Without Borders (MSF) at the end of 2015. Jordan recently returned from Aweil, South Su running the paediatric, neonatal ospital.

Aweil hospital: Aweil est maternal and infant mortality rates that involved working with people eing a doctor offered, as well as th as. Médecins Sans Frontières (MSF), wi od security, was an obvious choice.

Joining MSF

The state hospital in eld assignment, has a catchment area of ient departments, providing a capacity age in three inpatient wards, a ne atient therapeutic feeding centre (ITFC assessed a minimum of 300 children per ose.

My role was as the paediatric ICU and neonatal doctor.

The hospital itself is very basic and the intensive care unit resembled nothing I had ever seen back home. In this case 'intensive' simply means that we can put the patients on oxygen and monitor them a bit more closely due to an increased nurse-to-patient ratio. No fancy equipment. Given our limited resources, the number of lives we manage to save there is staggering.

Malaria season and food shortages

When I first arrived in Aweil the malaria season was ramping up and the vast majority of the patients we were seeing had the disease. The most common presenting complaints were coma or seizures, fever, or difficulty breathing. The malaria medicines work quickly, and I got used to the almost miraculous recoveries of children who were

critically ill. But too often they arrived too late, with complications that were too severe to reverse.

We also began to see an increase in severe acute malnutrition, or SAM. Food security was deteriorating in the region, partly due to a very short rainy season but also resulting from conflict and population displacement. Malnutrition came with many complications and children were being admitted with infections which, although normally easily treatable in well-nourished kids, were often life-threatening due to SAM-related reduced immune functioning.

With food so scarce, the arrival of the mango season brought relief with fuller bellies, but also many accidents. Children were falling from the trees, and coming to the hospital with fractures, abdominal trauma and head injuries. These diagnoses made up a significant part of our morbidity and mortality.

However, the patients who will always stay with me are those from the neonatal ward.

Stories from

To me, the very pres the region. The unit offered care to p neonates, children who simply might nc ould stay for a long time – anywhere bet rm strong bonds.

We had one pre-terr e. Her name was Miriam.

Miriam's birthweight e quite a few of our preterms, she had *N* times after beginning to feed a ract, causing damage and infectio e of infants who weigh less than 1.5 k ath.

Treatment for NEC c owel rest, gastric decompression, fluic nd prompt antibiotic therapy. M ven in a high-tech hospital with access to specialist neonatal surgeons, the baby could die and will often have life-long medical complications. Here in Aweil, the greatest danger was that Miriam's bowel would rupture, the outcome of which would certainly be fatal.

So we stopped Miriam's feeds, treated her with antibiotics and then very gradually reintroduced the feeds. And she didn't die.

Syphilis often goes undiagnosed in resource-poor areas

But Miriam did stay very unwell. Her blood count dropped, a condition called anaemia, which was severe enough to require a transfusion. Anaemia itself is not unusual in premature babies, but it becomes serious when complicated with other medical issues. Unfortunately, two days later, her red blood cell count had dropped again, much too

quickly. Although I wouldn't think of it immediately back in Australia, this pattern made me think of congenital syphilis; by this stage I had seen a number of classic presentations, which I had previously only ever read about in the textbooks. I now suspected mother-to-child transmission of syphilis.

Nearly a million pregnant women worldwide are infected with syphilis annually, resulting in early fetal loss and stillbirth, neonatal death, low-birthweight infants and serious neonatal infections. Normally, infections should be picked up by routine serological screening during pregnancy, and treatment with penicillin is simple and cheap. But the reality is that many women in South Sudan have only very limited access to antenatal care. Combined with the lack of diagnostic tools adapted to these poor-resource settings, it means a significant number of pregnant women with syphilis go undiagnosed.

Forming close connections with patients

Miriam tested positiv gave her supportive care with er red blood cell production recovere aternity unit for treatment as well.

Over the next few w s acute illnesses, continued to increas gained weight. Eventually she reach stfeeding beautifully and her r of normal, had stabilised. After 55 c

I found it very hard t

Looking bac

Fieldwork has really e much in the way of diagnostic facilitie it on a combination of histo I think it has helped make me a better cli

And then there is the exposure to the pathologies. I had a Master of Public Health and Tropical Medicine under my belt and had read a lot about malaria before I arrived in Aweil, but I had never seen it. I let the national staff teach me a lot and took my lead from them. But after a week I'd seen so many cases, I began to feel more comfortable.

Another skill I developed was simply being able to deal with whatever came in.

I had received little exposure to trauma in my training so far and in Australia, whenever a case arrives, we have a whole trauma team and a host of specialists to refer to. Now whatever the trauma, at least I now know where to start. I have an approach.

But perhaps the most rewarding part for me was the clinical education and capacity building. I had a lot of opportunities to work with the national staff who were almost

universally motivated and dedicated. In a country with such low literacy rates, they have had to fight for opportunities to learn and education is highly prized.

Valuable cross-cultural experiences

My opportunities to learn from the national staff were endless. Not only did they share their knowledge of the things that we just don't see in Australia (malaria, malnutrition, measles, tetanus), but they would also sit me down and teach me about their culture, politics, life in the village, and their language, supporting me to stumble through some sentences in Dinka.

Learning the best ways to convey information and how to work differently with different people was also exciting and rewarding. There's nothing quite like running a training session and then seeing that newly acquired knowledge or skill being applied in practice.

The experience has c I am leaning more towards doing paedi l'd never considered before.

And I will definitely v settings was something I loved. It

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