# GHFVP Reflection – Masanga Hospital, Sierra Leone

## Motivation

For years I've been interested in global health and humanitarian work. Completing a diploma in tropical medicine in East Africa through LSHTM cemented this, and I knew I wanted to work abroad for both the clinical exposure and to experience life in very a different setting. However, I struggled with confidence – "am I ready" etc. I heard about the global health fellowship and started looking into options. Unfortunately, COVID and then ACCS training delayed my placement by a few years, but after CT2 and PACES I felt more able to 1) Trust my ability as a clinician and 2) Believe that I could deliver some vaguely sensible teaching.

I heard about Masanga through friends who had worked there previously. It is a small (~130 bed) rural hospital in central Sierra Leone. The senior hospital staff include three Surgically Accredited Community Health Officers (SACHO – long term posts), 3-4 Dutch tropical doctors (couple of years at a time), and 2-3 UK doctors (~6 monthly rotations). Masanga is the base for Sierra Leone's surgical and paediatric training programmes for clinical officers, and more recently also shares responsibility for a medical training programme (MTP) run out of Koidu hospital in Kono District. Training for the MTPs is delivered by the UK doctors. Masanga is one of the most active hospitals in the country surgically and has a large research department, which has assisted in the development of the hospital's lab.

## Medicine in Masanga

The UK doctors who rotate through Masanga are primarily tasked with supervising the running of the emergency unit (16 beds), isolation unit (4 beds) and outpatient department. There is some expectation to cover paediatrics out of hours – intimidating but heavily protocolised and with a back up on call for any problems. The maternity and surgical units are run by the SACHOs and Dutch tropical doctors. The surgical unit has 50 beds and 2 nurses at most – it is therefore generally only for self-caring patients, and those who get unwell are transferred back to the EU.

Most of our admissions have surgical pathology. This is often caused by trauma, due to either road traffic accidents or falling out of mango/palm trees. Patients often present late after weeks of management by traditional healers. Sometimes the affected limb has become completely necrotic, and I saw several cases with associated necrotising fasciitis. There are a surprising number of patients with GI perforation, due to peptic ulcer disease (uncontrolled steroid and NSAID use especially by miners, likely high prevalence H. Pylori, fasting during Ramadan etc) or typhoid.

Medical admissions are often to the isolation unit. New diagnoses of TB often co-present with acute heart failure – something I did not expect and am interested to know if it happens to the same extent elsewhere. I learned how complex managing a patient with advanced HIV can be, especially when they present with neurological signs and with our limited lab. A few patients with rheumatic heart disease came through also, with impressive clinical signs. Hepatitis B has an estimated seroprevalence of 18% in Sierra Leone and the sequelae of this (cirrhosis, HCC, varices) were also seen reasonably frequently. This was particularly difficult as there is so little that we can offer. I learned the value of ultrasound, particularly for imaging lungs when portable CXRs (let alone CT!) are not available. History taking was also remarkably difficult, often requiring 3 step translation from Temne through Krio to English!

Paediatrics was my biggest source of stress – phone calls at three in the morning about hypoxic neonates and seizing infants were grim. Fortunately, the third on calls (Dutch/SACHOs) were always approachable, and the protocols were easy to follow. It was rewarding to feel slowly more comfortable

on the paeds ward, and with unfamiliar treatments like phenobarbital or bubble CPAP. Whilst children often arrived incredibly unwell, they usually responded quickly to simple management. Paediatric deaths were sadly not infrequent, and discussing cases at handovers or the monthly mortality meeting was very useful for identifying ways in which care could be improved.

A big part of my work in Masanga was teaching. Much of this was informal/bedside, but it was also a formal part of our role – the two other UK doctors (Mark and Miranda) and I ran two nine-week programmes for MTPs rotating from Koidu, with modules on cardiology, respiratory medicine, and gastroenterology. Our teaching included lectures and simulation sessions. I still have work to do to become a good educationalist, but I learnt a lot and it was great to see the students become more confident and apply their knowledge clinically. The culture of learning in Masanga is exceptional – most handovers included a case-based discussion, trainees presented weekly on the Friday grand round, and within seconds of giving any bedside teaching you'd be surrounded by interested medical staff.

## Interests

Alongside the above, I spent plenty of time working on side projects. Whilst my background is in medicine, my future is in anaesthesia and ICM – it was nice to spend a bit of time in theatre supporting the anaesthesia nurses. I was able to continue the work of a Dutch anaesthetics trainee introducing halothane draw over anaesthesia. I also ended up helping the medical superintendent in the design of a new isolation and care unit, liaising between Architects Without Borders and a WHO panel of experts – this was fascinating! My biggest interest ended up being snakebite however, after a 17-year-old bitten by a mamba sadly died from neurotoxicity. I created a protocol for the hospital, and successfully applied for funding to carry out a survey of snakebite morbidity and mortality. The project has grown significantly to cover Tonkolili District. I hope I haven't bitten off more than I can chew!

## Life in Masanga

Generally, life was slow. I did a lot of running, including a spectacular day trip over a nearby mountain pass and a long day attempting to run to Yele. As the rainy season arrived, I stuck increasingly to the roads as the paths through the bush became more overgrown. We often played volleyball in the evenings, and occasionally visited one of the village bars. I brought a pair of binoculars with me and enjoyed wandering about trying to spot great blue turacos. I did manage a few brilliant weekend trips however, to Tiwai island (where we saw 6 different monkey species), Kabala (a town in the North surrounded by beautiful hills) and to Freetown/the beaches of the Peninsula. In retrospect I should have taken more time off – one week in five months was not enough!

## Coming home

I've been home for a fortnight. Initially everything was very exciting – various foods were mind-blowing (particularly a yoghurt and apple juice on my first flight) and it was so nice to see friends and family. I'm a little under the weather, tired all the time to the extent that I've had a GP appointment (also for the 15kg weight loss and lymphadenopathy, I think explainable by lifestyle changes and an infected mosquito bite but not ideal…). The main thing I have found difficult so far is the idea that I may have contributed negatively. Corruption is endemic in Sierra Leone. Stories of ministers describing health and education as "for NGOs to sort out" and falling health spending are disheartening. At least the money coming into Masanga is traceable and accountable, and the good done by the hospital is very clear to see. Keeping in mind my original motivations of clinical exposure and living in the tropics helps too – I feel like I have achieved these! Work in Masanga also felt more vocational than work in the UK, and I hope this is something I can maintain. I'm grateful for the opportunity I've had.