GRUELLING HIKES, BONE-CRUNCHING DRIVES, A SPECTACULAR SUNRISE AND REAWAKENED VISION

Some of our readers have been privileged to attend international conferences in exotic locations. Others have worked in unusual places around the globe. Readers are invited to share their stories of 'different kinds of places' in this series.

This month MIKE LEVIN tells of a visit to a rural clinic in northern Malawi, and reflects on primary health care.

LIVINGSTONIA IS LOCATED IN MALAWI'S NORTHERN region on a plateau 867 metres above the level of Lake Malawi. An earth road winds steeply up from the lakeshore to Livingstonia and is a gruelling four hour walk or equally bone-crunching three-quarter hour drive. Once on the plateau, one can see beautiful views of the lakeshore and on a clear day one can see right across the lake to Tanzania. The area is thinly populated and there is no public transport to Livingstonia.

Malawi is the 13th poorest country in the world[1] and most people are subsistence farmers living below the poverty line, struggling against hunger and starvation.[2] In Livingstonia lies DGM Hospital, a rural hospital with two general wards, OPD, maternity block and a small laboratory and rudimentary theatre facilities.

Primary health care (PHC) is an important component with four rural clinics offering family planning, maternal and child health, water and housing projects, nutrition work, health education and training. The clinics are even more inaccessible. The most far flung is at Tcharo, about 80km south of Livingstonia along the shore of Lake Malawi, 30km south of another clinic at Mlowe. Access to Tcharo is either by boat down the lake – a steamer stops there once a week – or by way of a six hour walk from Mlowe which itself is accessible only by a poor dirt road. It was to this rural clinic that I paid a visit on the spur of the moment after meeting the clinician in charge, Dr Colin Fischbacher at Livingstonia. Dr Fischbacher is the only doctor working in the Livingstonia project and the health centres. Most of the medical work is done by medical assistants and medical orderlies – people with little or no formal medical training who learn on the job all they need to know. Dr Fischbacher himself visits each rural health centre once a month to solve problems and give ongoing advice and training.

We left Livingstonia on a Sunday afternoon. The view while descending the plateau was astounding. Green forest-covered mountains drop steeply to a thin stretch of arable land and then a rim of sand lines the lake. The first stop was Luwichi Health Centre where we toured the buildings – similar in design and form to many of our township day hospitals and MOUs. The next stop was Mlowe.

Thirty kilometres south of Livingstonia a dirt road branches off and crosses the large South Rukuru river via a wooden plank bridge. The health centre has a small ward and nutrition centre and sees almost 3 000 patients a year. There are no telephone or radio, no mains electricity, few beds and little bedding. We settled in for the night in preparation for an early start the next morning. On Monday at 04h30 we woke and drove the short distance to the shore where we waited in the dark for the ferry, the 'MV Ilala' to arrive. We boarded the ferry in two battered motor launches

among a cacophony of sound – fellow travellers with heavy loads jostling for the best positions. The sun rose as we were steaming south down the lake – a spectacular sight of distant clouds and rain backlit by the rising sun. Just over an hour later we reached Tcharo. The area is hilly and green, a few traditional huts scattered across them. The clinic nestles in a small bay with its own beach and tiny offshore island.

The health centre comprises a small outpatient room, office, medicines room, injection room and maternity and general wards. The building itself is solid and secure on a well laid out plot. Water is pumped from the lake by a windmill. There is no communication or generator and the fastest way to get hospital care in an emergency is to be carried four hours on a dugout canoe to Mlowe where the patient faces a nine kilometre walk to the tar road and then a bus to Rumphi (40km) or to the turnoff to Livingstonia where the ascent must be made by foot or on passing vehicles.

We arrived at about 06h30 and met the medical orderly, Mr Funkha, an amiable gentleman with an open and welcoming nature. He and his co-worker, Miss Ngwira, are responsible for running the outpatients department and maternity, as well as community projects. Mr Funkha has obtained a standard six education and further training in his more than 15 years' service with the project. He will see about 2 500 patients and attend over 100 births in his next year and be the first line of medical contact for the people in about a 20km radius. His medical knowledge is rudimentary and his skills are poor. This notwithstanding, he will diagnose and treat about three quarters of his patients effectively. He will see many young infants under five and most commonly diagnose pneumonia, URTI, malaria, diarrhoea and asthma, and give immunisations.

We saw about 10 patients on the day and reviewed the diagnosis of pneumonia in infants and the importance of relying on respiratory rate and recessions as diagnostic criteria rather than auscultating the chest. Dr Fischbacher also did a brachial block and an I&D on a severely infected hand of a young man and prescribed IV antibiotics. The rest of the day was spent talking with local children and villagers, taking meals with the staff and swimming in the lake. The centre is not very busy and there seems to be plenty of time for leisure and relaxation.

The following morning we woke at 04h30 and set off for the first half hour along a hillside path in the dark. The sun rose while we trudged steadily on through the morning past villagers tending their cassara with traditional hoes. Malnutrition is common and dependence on a single crop makes the community very vulnerable.

After five hours of walking we reached Zunga Health Post – a small ramshackle building run by a single medical orderly, Mr M Ngwira. Here we stopped to help Mr Ngwira treat an apathetic baby with a high fever – probably ill with malaria – by giving Fansidar and reviewing the preparation of ORS. From here it was a two hour walk back to Mlowe and the awaiting car.

The rural clinics are very well organised and seem to be effective in the diagnosis and treatment of outpatients, but there seemed little evidence of large scale community involvement or non-medical development activities. Since my idealistic days in medical school, where I looked up to David Werner and local people like Dr Ivan Toms, my enchantment with PHC began to wane. I started to see PHC as expensive and ineffectual – a dream that so often could not work. I feared being stuck in hospital-based curative medicine the rest of my life. Yet in the Livingstonia project I can see the potential for great fulfilment and satisfaction in the provision of a local service that could fulfil the ideals of PHC. Strides forward are being made in immunisation work and the protection of local wells. But more person-power and staff training as well as preventive and promotive measures are needed. Dr Fischbacher admits that there have been really difficult times but that in general it is very rewarding.

I would like to thank him and his staff for the opportunity to see and experience the type of work where my future may lie.

Mike Levin graduated in medicine at UCT in 1994. He completed his internship at Cecilia Makiwane Hospital in Mdantsane before donning his backpack and guitar and heading north.

REFERENCES:
1. World Bank World Development Report 1993.
2. Malawi Demographic and Health Survey 1992. Situation Analysis of Poverty in Malawi. Government of Malawi and United Nations. Lilongwe 1993.

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