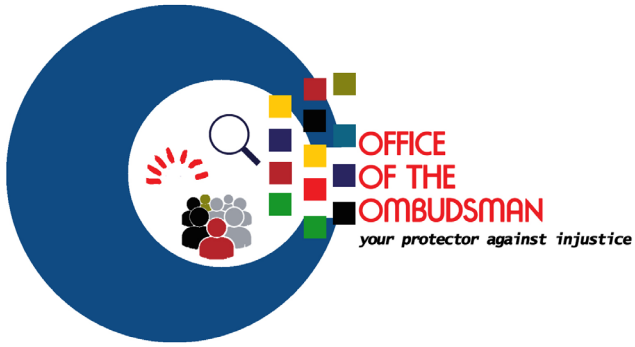
Woes of the Womb

Office of the Ombudsman

AN INVESTIGATION INTO ALLEGATIONS OF MEDICAL MALPRACTICES RESULTING IN REMOVAL OF UTERUSES FROM EXPECTANT WOMEN IN PUBLIC HEALTH FACILITIES


OFFICE
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A REPORT ON AN INVESTIGATION INTO ALLEGATIONS OF MEDICAL MALPRACTICES RESULTING IN REMOVAL OF UTERUSES FROM EXPECTANT WOMEN IN PUBLIC HEALTH FACILITIES

AUGUST 2019

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EXECUTIVE SUMMARY

"Learn to respect this sacred moment of birth, as fragile, fleeting, as elusive as dawn."
Frederick Leboyer

"Woes of the Womb" is my report as the Ombudsman of the Republic of Malawi on an investigation of alleged malpractices resulting in removal of uteruses from expectant women in public health facilities.

The investigation was conducted following a news article carried by Malawi News of 9th June, 2018 titled *"Creation of a Barren Nation"* which was followed by a report by Zodiak Broadcasting Station in August 2018 both of which alleged that uteruses were being removed from caesarean section patients at an alarming rate at Queen Elizabeth Central Hospital. During the investigation my office reviewed relevant documentation; interviewed medical personnel; Ministry of Health and Population officials; members of regulatory bodies; patients and family members; and other relevant stakeholders.

The investigation made the following findings:

1. The Ministry of Health and Population has failed its duty to provide sufficient staff to cater for the needs for Obstetrics and Gynaecology Departments in all health facilities resulting in compromised quality service delivery in the country. Moreover, in other health facilities where the Ministry of Health and Population appears to have exceeded the staff establishment, the same has been found to be largely insufficient in reality to meet the actual demand within the catchment area clearly showing that such staff establishments are outdated.
2. There is insufficient ward space, beds and theatres in some central hospitals in the country resulting in delays in assisting patients as well as compromised sanitation in the wards, both of which have contributed to the increased number of maternal infections and attendant uterus raptures in some instances. This has contributed to the number of hysterectomies and even resulted in deaths. It is the obligation of the Government to provide these to its people. Failure to provide the same amounts to breach of duty by Ministry of Health and Population.
3. Shortage of drugs and medical equipment is a common feature in the health system in the country and the sad part is that despite this being a serious issue it is no longer alarming, it has become part of our lives. However, fact remains that this problem affects real people. In Obstetrics and Gynaecology the stakes are high because there are two lives involved and where hysterectomy has been conducted it is not only the social cultural standing of the woman that is affected but the country's potential demographics as well.
4. Common occurrence of shortage of drugs in the hospitals speaks to systems failure and neglect of duty. Whilst this may not be a representation of the whole country, our investigations revealed that there is a problem of inadequate or no drugs in

some lower level health facilities, which are meant to increase accessibility of health care and reduce congestion in central hospitals.

5. The very fact that there is a bypass fee is an acknowledgement that the structures that are in place are not working to the satisfaction of health service users at lower level health facilities. This points to the fact that the said medication that is supposed to be available at lower level health facilities are not even there.
6. Shortage of ambulances and/or fuel in most of the health facilities contributes to the delay of transporting emergency Obstetrics and Gynaecology patients to referral hospitals for immediate medical attention. This also results in worsening of the condition such as uterus rupture of the patients leading to either hysterectomy or death. Failure to provide ambulances/fuel is an omission of duty on the part of Ministry of Health and Population.
7. Most of the disturbing incidents of hysterectomy are those arising from pure negligence and lack of care on the part of health personnel. This as it may, only few of such medical personnel are held to account for their misconduct. Due to their socio-economic status the majority of patients do not feel empowered enough to speak out thereby obliging the Ministry of Health and Population to put measures to protect them. Whilst some strategies have been put in place, the same are not far reaching and are/or subjected to heavy resistance and defensiveness from the health personnel themselves. The failure by the Ministry of Health and Population and Regulatory Bodies to effectively hold such health personnel accountable for their actions is unreasonable, unfair and amounts to maladministration.
8. Queen Elizabeth Central Hospital has a lot of water leakages due to obsolete water pipes, which the Ministry of Health and Population has neglected to repair. The leakages are contributing to low pressure of running water and in turn affecting general cleanliness of the hospital with high stakes for Obstetrics and Gynecology sections.

The report further presents directives and recommendations aimed at providing redress to the maladministration proven by the investigations as follows:

a) Short-term interventions

1. Ministry of Health and Population to engage with Ministry of Information, Civic Education and Communication Technology to popularize the contents of Pharmacy and Medicines Regulatory Act, 2019 with particular emphasis on the penalties for contravening its provisions. The popularization should target the general public and also Prosecutors, Magistrates and Private Pharmacies. Further, the collaboration should work on disseminating information contained in the National Community Health Strategy (2017-2022) which aims at ensuring that health services are accessible and patient-centred. I direct that a report should be submitted to my office by 31st January, 2020.
2. Queen Elizabeth Central Hospital should carry out plumbing maintenance at the

hospital which will eradicate leakages and also reduce low water pressure problems. This should be done by 31st January, 2020.

3. Queen Elizabeth Central Hospital in consultation with Blantyre Water Board should explore the possibility of having dedicated water supply line in order to curb the current water supply shortage. A report of the resolution should be submitted to my office by 31st January, 2020.

4. I strongly recommend that the Ministry of Health and Population and the regulatory bodies should vigilantly and impartially discipline all health personnel guilty of acts of misconduct in order to deter other medical personnel from negligently conducting their duties.

b) Long term interventions

5. Ministry of Health and Population having assessed its existing staff establishments of doctors and nurses in all health facilities and considering that the functional review process is at an advanced stage, I direct that this process should be finalised by 30th June, 2020 and a report furnished to my office.

6. In my report titled *"Out of Sight, Out of Mind"* released in December 2017 I had directed the Secretary for Health to facilitate a review of existing physical structures of its district hospitals by March 2018 in order to assess the possibility of establishing mental unit. During this investigation Ministry of Health and Population acknowledged that the assessment has been done and that it has covered all areas of health care including Obstetrics and Gynaecology awaiting construction/expansion of its facilities. In light of the steps already taken and efforts to strengthen the already existing facilities and renovations at Queen Elizabeth Central Hospital Chatinkha Maternity Wing and the additional theatre under construction by Medicins Sans Frontiers, France, I direct that budgetary allocations should start from 2020/2021 financial year and the constructions and renovations should be done by 2025.

7. In compliance with the Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases, April, 2001, that requires all parties to ensure that 15% of the annual national budget should be allocated to the improvement of the health sector, it is strongly recommended that Malawi complies with this obligation by 2022. This will effectively resolve some of the problems relating to financial resources considering that the right to health is a socio-economic right, whose obligation is placed on the State to achieve progressively. In addition, the District Commissioners should ensure that funds meant for the health sector are utilized for their intended purpose.

8. Central Medical Stores Trust being the source of pharmaceutical supplies in public hospitals, should be one of the most prioritized Institutions to be well funded by Malawi Government, as its system failure negatively affects a larger population of Malawians. It is therefore recommended that Treasury should increase and prioritize

funding to Central Medical Stores Trust to ensure round-the-clock availability of pharmaceutical supplies.

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ABBREVIATIONS

AMR	Antimicrobial resistance
CMST	Central Medical Stores Trust
EMCM	Essential Midwifery Competencies for Malawi
K.C.H	Kamuzu Central Hospital
MDG	Millennium Development Goals
MoH	Ministry of Health and Population
NMCM	Nurses and Midwives Council of Malawi
OoO	Office of the Ombudsman
Q.E.C.H	Queen Elizabeth Central Hospital
SDG	Sustainable Development Goals
SRN	Senior Registered Nurse
The Constitution	1994 Republican Constitution of Malawi
Zodiak	Zodiak Broadcasting Station

GLOSSARY

Abuja Declaration, 2001	Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases, April, 2001
Hysterectomy	A surgical operation to remove all or part of the uterus
Maternal sepsis	Life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs
Midwifery	Encompasses autonomous provision of support, care and advice in partnership with the women to promote self-care and the health of mothers before, during pregnancy, labour and following childbirth. It also includes provision of care to infants, children, adolescents and families. It further involves promoting respect for human dignity and for women as persons with full human rights. It advocates for women so that their voices are heard, is culturally sensitive working with women and other health care providers to overcome those cultural practices that harm women, newborns, infants, children and adolescents. (Adapted from ICM global definition 2005)
Primary and Secondary Health Delivery Levels	These belong to the district health system under the mandate of the councils
Prophylaxis	Treatment given or action taken to prevent disease
Scrub nurse	Nurse who assists the surgeon in an operating room
Suturing material	Material used in closing a wound with stitches

A. THE BASIS OF THE INVESTIGATION

Media report

1. My investigation was triggered by a news article carried by Malawi News of 9th June, 2018 titled *"Creation of a Barren Nation"* and a report that Zodiak Broadcasting Station (Zodiak) aired in August 2018 both of which alleged that there is an alarming rate at which uteruses were being removed from caesarean section patients at Queen Elizabeth Central Hospital (Q.E.C.H).
2. The reports stated that Q.E.C.H was not administering prophylactic antibiotic to the women who undergo caesarean section to avoid infection. It was alleged that painkillers were being given instead.
3. Consequently, the wounds were developing infections leading to the removal of uteruses. The report indicated that approximately 20 such cases were registered in July 2018 alone.
4. Other challenges highlighted in the report included shortage of health personnel in maternity wards, congestion and poor sanitary conditions.
5. Instead of looking at the allegations in isolation, I decided to embark on a systemic investigation due to the following factors:

    a). To examine systems in place in respect of maternal health especially Obstetrics and Gynaecology issues in all central hospitals.

    b). This is an area where a class of people (women) are affected primarily, but the effects would eventually be felt across the country.

Individual experiences from members of the public

After a decision was made to adopt a systemic investigation approach, my office requested those with information or experiences relating to the matter at hand to come forward and present their issues. Below are the experiences that were shared by some of the concerned members of the public.

Individual 1:

When my labour pain started I visited Ndirande Health Facility where I spent three days for observation. I requested to be referred to Q.E.C.H as I was not being attended to. Upon my arrival at Q.E.C.H I was examined and told to wait for an operation. I waited for one more day before caesarean section. Prior to the caesarean section I was given medication. I delivered a healthy baby and was released after 4 days. However, my wound was producing a lot of watery substance.

I experienced this before I was discharged but nonetheless I was still discharged despite reporting my condition to the medical personnel at Q.E.C.H. The condition worsened and I returned to Q.E.C.H where I was taken back to theatre and had my wound reopened and my uterus removed. The medical personnel explained that I had developed an infection which led to removal of the uterus.

I was discharged after three days. A week later as I was recovering, my wound opened immediately after coughing. When I went back to Q.E.C.H I was taken into the theatre for the third time. After the procedure, I was advised by my friend who works at Q.E.C.H to seek an explanation from the medical personnel as to what they had found in my body when I went into theatre for third time. I suspect that a foreign object might have been left in my body during the second procedure.

Individual 2

I was pregnant with my third child. I delivered two of my children through caesarean section. I was doing my prenatal at Machinjiri Health Centre. When my due date was close I was advised by the Medical Assistant at the centre that I needed to go to Q.E.C.H so that the personnel there could schedule a date for my delivery since I had to deliver through caesarean section. I complied and was given a date for delivery.

I delivered and was discharged. However, while at home I was not recuperating well in terms of my wound. I therefore returned to the hospital where I was informed by the doctor that my wound was not healing properly, and was taken to theatre for cleaning. Nonetheless, the situation did not improve. Therefore I was taken back to the theatre where the doctors discovered that my uterus was septic and had to be removed. This was done. The baby was well but I do not know what happened that led to the removal of my uterus.

Individual 3

On 13th January, 2018 my wife was expectant and we went to Salima District Hospital in the morning. She spent the whole day there and at 4.00 p.m. the nurse who was on duty was knocking off and she left a word with the one who took over from her that in the event that the patient would not deliver by 6.00 p.m. then she has to be referred to theatre. There was a wall clock in the room and at 6.00 p.m. my wife reminded the nurse to go to theatre but she was told to wait.

At 7.00 p.m. the nurse told my wife that she wanted to eat first. At 8.00 p.m. a certain nurse came into the room because she had forgotten her item in the room. She questioned as to why my wife was still in the room and they responded that they wanted to eat first and attend to her. The visiting nurse just put on gloves and took my wife to theatre. When they got into the theatre it was observed that the uterus had ruptured. My wife had given birth before by caesarean section. And this was explained to the nurse who kept her waiting but she did not care. It was observed that the child had died. I wanted to take the matter further but my wife said that she does not feel happy to be reminded of this ordeal but as a husband I am equally concerned.

Individual 4

When labour pain started I went to Mdeka Health Centre where I was informed that my birth canal was small and was not progressing. It is when I was referred to Q.E.C.H. I was advised that I could not deliver normally instead I should go for operation. I spent a night at Mdeka then the following day I was referred to Q.E.C.H by ambulance. Q.E.C.H confirmed that indeed I had a narrow birth canal and it is when they decided to do a caesarian section. I was 20 years old. It was on 16th June, 2018 when I went to Mdeka Health Centre and on 17th June, 2018 I delivered

a baby, my first child at Q.E.C.H through caesarian section. The following morning when they did the operation, I noticed that my stomach was swollen. So I was sent to theatre again where I was told that my uterus was damaged. Doctors made the decision to remove it and it was done. I have never undergone any surgery before. I was not given any medication before the caesarean section but I was given medication after giving birth but before being discharged. Later on when I went for the second time I was also being given medication after the doctors noticed that there was some pus/fluids coming out of my wound. When I started taking the medication the wound's condition got worse than before. But I cannot remember the type of drug I was given because I was critically ill by then. I stayed in hospital after the uterus removal operation from June to August end (three months). When I was in hospital they used to clean the wound and nursing me. I used to go for check up till they told me to stop. The wound is still not in good condition. Since then my mother was the one taking good care of me and at times I could go to our then nearest hospital, Lirangwe Health Facility. I am very worried because they violated my rights of having many children. In addition, I could have lost my life because of the way I was handled. I am not married. I want some compensation in form of money.

Individual 5

"I am a former employee of Q.E.C.H. I have worked with well-known doctors in the Gynecology department for a long time. In July 2018, my sister gave birth to a stillborn at Q.E.C.H. She was assisted by an intern doctor from College of Medicine who wrote on her forms that "senior nurse to review" after noting that some parts of her placenta had remained in her uterus.

At the time my sister was delivering, there was only a nurse technician and not a Senior Registered Nurse (SRN). The nurse technician was the one supervising the intern doctor.

My sister's placenta was removed around 3 pm. However, part of the placenta remained in the womb up to 7pm. When I saw this, I inquired about the procedure from the intern doctor who informed me that he was waiting for the SRN to review. I further pestered them that as per medical procedure, they were supposed to take my sister for (placenta) evacuation as this was an emergency. However, my cries fell on deaf ears. They further insisted that her condition will be reviewed the following day.

To cut the long story short, she slept without being removed the parts of the placenta. We tried to reason with them to do the evacuation process the same night but they insisted that we wait the following morning.

Unfortunate enough, she wasn't reviewed by the nurse that night and we waited for over 10 hours up to the time she went into a septic shock.

Upon noting the worsening condition, the following morning I went to the In-charge doctor at the Gynecology department. After explaining to him my situation, we rushed to the ward so that he inspects her. Upon seeing her condition, the doctor instructed the nurses to take her straight away to the theatre. He further requested us if possible to buy some drugs as they had run out of stock of those drugs. We rushed and bought the drugs at a nearby pharmacy for about MK20, 000.00.

At the theatre, the doctor noted that my sister couldn't withstand the anesthesia because her

condition deteriorated within minutes. She went into a semiconscious coma as her blood started to clot in her veins. However, we managed to stabilize her condition as the doctor ordered a drug called Heparin.

All this was done so that they could stabilize her so that they do the evacuation process again. She was stabilized and taken to theater for the evacuation process. Unfortunately, it was the same intern doctor who did the process. It wasn't done to perfection and as per standards.

The following day, the condition worsened to a point that we decided to take her to a private hospital as she had developed gastritis infection and had retained placenta products which forced her uterus to swell.We took her to Seventh-Day Adventist Hospital where we spent around MK1.2 million just because of the negligence and inexperience of someone. I was so angry at Q.E.C.H officials to the point that I wanted to sue them.

All in all, I can summarize Q.E.C.H problems in this way. Firstly, there is too much workload at Q.E.C.H against few officers (nurses and technician inclusive). They really have a staffing challenge. They are just few employees. They should consider employing more nurses and get rid of "locum" as they don't pay much attention when on locum. Q.E.C.H lack experts who can do the actual work and also mentor the interns.

Another problem is that senior doctors are not available to supervise and monitor the intern doctors. Most of them are so much concerned with their private clinics or part-time jobs. There is lack of supervision on interns by the medical doctors. No wonder College of Medicine intern doctors are so much interested to get hysterectomy numbers in order to qualify to the next level. Related to the point above, there is need to have stationed qualified doctors who can concentrate working at the station and not in their private clinics. Doctors have a tendency of paying special attention to their private jobs.

There is also a tendency at Gynaecology department that once someone is diagnosed with a fibroid, they rush to do a hysterectomy. I personally saved about 6 women who were on their way to the theatre for hysterectomy just because they had a fibroid"

B. ISSUES FOR INVESTIGATIONS

Based on the report and information gathered from the public, my investigation focussed on the following issues:

1. Whether Ministry of Health and Population (MoH) or health personnel are guilty of maladministration in their handling of pregnant women;
2. Whether and to what extent the said acts of maladministration are leading to removal of uteruses.

C. LEGAL MANDATE OF THE OMBUDSMAN

The Office of the Ombudsman (OoO) is an independent institution established by the 1994 Republican Constitution of Malawi (The Constitution) and is complemented by the 1996 Ombudsman Act. From a combined reading of section 123 of the Constitution and section 5 of the Ombudsman Act the mandate of the Ombudsman is to investigate

allegations of injustice, abuse of power, unfair treatment, manifest injustice, oppressive, unreasonable or unfair conduct.

D. INVESTIGATIONS APPROACH

The following methods were used to gather evidence:

1. A notification was served on the Secretary for Health of the intention to conduct systemic investigation and an acknowledgement was received providing a focal person for the investigations;

2. Desk research was conducted on legal and policy documents such as the Constitution; National Health Policy (March 2018); Health Sector Strategic Plan II (2017-2022); Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases, April 2001 (Abuja Declaration, 2001), Obstetrics & Gynecology Protocols and Guidelines, Malawi (September 2014); Medical Practitioners and Dentists Act; Charter on Patients' & Health Service Providers' Rights & Responsibilities; Essential Midwifery Competencies for Malawi (November 2012); Code of Ethics for Midwives (2016); Pharmacy, Medicines and Poisons Act and Pharmacy and Medicines Regulatory Authority, February 2019;

3. Interviews with relevant stakeholders such as health service personnel at Q.E.C.H, Kamuzu Central Hospital (K.C.H), Mzuzu Central Hospital, Zomba Central Hospital, College of Medicine; Bwaila District Hospital, Medical Council of Malawi, Nurses and Midwives Council of Malawi (NMCM) Blantyre District Health Office, Zomba District Health Office, some of the affected people, Secretary for Health and other Senior Officials from MoH Headquarters, Central Medical Stores Trust (CMST) Blantyre Water Board and Zodiak.

E. SCOPE OF INVESTIGATIONS

1. The investigation was primarily centred on processes and procedures followed during caesarean section at Q.E.C.H.

2. In order to draw a comparison, the investigation was extended to other systemic factors that contribute to the possible removal of uteruses in central and district hospitals.

3. The investigation further engaged other stakeholders such as Medical Council of Malawi, College of Medicine and Blantyre Water Board, as the operations of these stakeholders affect the efficiency of the hospital operations.

F. OBLIGATIONS OF THE INVESTIGATION TEAM

The obligations of the investigation team were as follows:

1. To act fairly, without bias and in accordance with the principles of natural justice, recognising the right to dignity, confidentiality and respect for all;

2. To make all reasonable enquiries and gather all relevant evidence before making any conclusion;

3. To complete the investigation in a timely manner.

G. EVIDENCE GATHERED

Legal and policy framework of Ministry of Health and Population in relation to maternal health

1. The Government of Malawi is obliged by the Constitution to provide adequate health care, proportionate to the health needs of Malawian society and international standards. Section 13 (c) of the Constitution provides that the State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation aimed at achieving the goal of providing adequate health care, commensurate with the health needs of Malawian society and international standards of health care.
2. The Medical Council of Malawi Code of Ethics places an obligation on medical practitioners to perform any act pertaining to the profession or calling in a competent, proper and graceful manner. It further requires the doctors to provide skilled and careful treatment of a complaint which has been properly diagnosed. The medical practitioner must have adequate training and experience.
3. National Health Policy objectives aim at improving service delivery by, among other things, promoting preventative health at all levels of the health care system by reducing risk factors and addressing social determinants of health; providing effective leadership and management that is accountable and transparent at national, and local authority levels; increasing health financing equitably and efficiently and enhancing its predictability and sustainability; improving the availability of competent and motivated human resources for health for quality health service delivery that is effective, efficient and equitable; improving the availability, accessibility and quality of health infrastructure, medical equipment, medicines and medical supplies at all levels of health care.
4. Competency 3 of the Essential Midwifery Competencies for Malawi (EMCM) requires them to provide high quality ante-natal care to maximize the health status during pregnancy and that includes early detection and treatment or referral of selected complications.
5. Further, Competency 4 of the EMCM provides that midwives are required to provide high quality, culturally sensitive care during labour, conduct a clean and safe delivery and handle selected emergency situations to maximize the health of women and their newborn babies. This includes ability to identify signs and symptoms that are life threatening to the pregnant woman.
6. Under ethical principles of the Code of Ethics for Midwives, Nurses and Midwives have an obligation not to do any harm by consciously refraining from acts that might cause harm of any nature whatsoever to healthcare users, individuals, groups and communities in accordance with Code of Ethics for Midwives.

7. According to section 82 of the Pharmacy and Medicines Regulatory Authority Act, 2019 a person who is convicted of stealing medicines and allied substances from a public Health facility is liable to a fine of K 20,000,000 and to imprisonment for twenty years.
8. Section 88 of the Pharmacy and Medicines Regulatory Authority Act, 2019 provides for a fine of K5,000,000.00 or five years imprisonment to persons that may be found in illegal dealings of drugs, conducting pharmacy business on unlicensed premises and assembling, importing, selling medicinal products without product licence.
9. Again as a member of the United Nations, Malawi signed the Millennium Development Goals (MDGs) (2000-2015) and the Sustainable Development Goals (SDGs) (2015-2030), both of which provide for improved wellbeing of all people and with specific targets on maternal health. Further to this, the MoH has developed a number of policies including the Health Sector Strategic Plan (2017-2022); National Community Health Strategy (2017-2022); and the National Health Policy (2018-2030) which provide a guiding framework for complying with the constitutional obligations and domesticating the international goals stated above.
10. As a result of these interventions, Malawi has made some progress in maternal and neonatal health as maternal mortality declined from 675/100000 live births in 2010 to 439/100000 live births in 2016.[1] According to Malawi Demographic Health Survey of 2010 and 2015 reports, there was reduction in neonatal deaths from 31/1000 live births in 2010 to 27/1000 live births in 2015. Despite having these achievements, there have been reports that pregnant women continue to experience poor quality health care and service, leading to development of complex health situations resulting in the removal of the uterus of some women and death in other extreme cases.

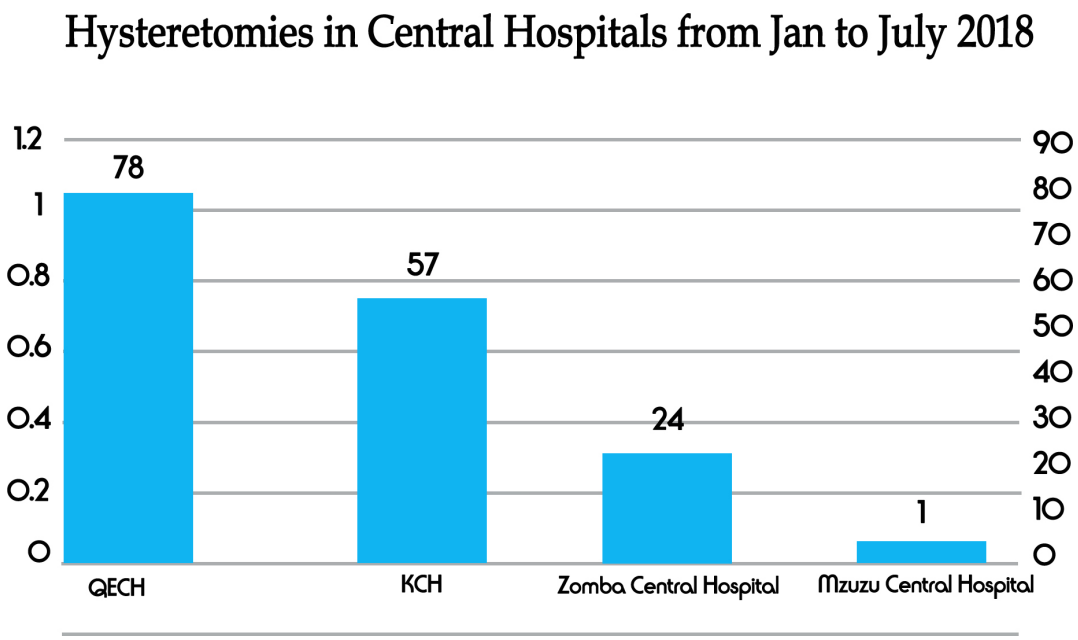
Evidence gathered from interviews with health facilities personnel

a) Statistics of uteruses removed in health facilities from January to July 2018

1. From January to July 2018 Q.E.C.H registered 78 total cases of hysterectomies but only 41 cases were analysed because other theatre books were missing. Of those 78 cases hysterectomies, 66 cases arose from caesarean delivery and 12 cases from vaginal delivery.
2. Mzuzu Central Hospital registered 1 hysterectomy case arising from caesarean delivery.
3. K.C.H registered 57 hysterectomy cases arising from caesarean delivery.
4. Zomba Central Hospital registered 24 hysterectomies.There was no indication as to how many cases arose from caesarean section or vaginal delivery.

[1]National Health Policy "Towards Universal Health Coverage", p.3

The graph below shows the number of hysterectomies in central hospitals



b) Staffing capacity

1. Clinical staff (doctors and clinicians) establishment was last reviewed in 2010/11 and 2017 at Q.E.C.H and Mzuzu Central Hospital respectively. K.C.H and Zomba Central Hospital were reviewed in 2007.
2. At the inception of this investigation, it was found that on average Obstetrics and Gynecology Clinical Section for all the central hospitals had 43% filled positions. The average Doctor to Patient ratio is 1: 58.
3. In terms of the Nursing Section, the filled positions in central hospitals was at 80%. The average Nurse to Patient ratio in all the central hospitals is 1:32.
4. During the investigations, MoH acknowledged the shortage of health personnel in all hospitals across the country. To mitigate this problem they are using locum staff to cover the gaps although these are not on full roaster for continued care in post-natal wards.
5. They however stated that as a permanent measure they were going to recruit staff which they intended to deploy to various facilities by 1st April, 2019. Our further inquiries from MoH Headquarters revealed that only midwives/nurses from grade K to I have been deployed to central hospitals.
6. It was stated however that functional review process is almost through and a draft is ready for discussion to mitigate shortage of personnel in the hospitals. The Department of Human Resource Management and Development stated that a draft report of the functional review was submitted to MoH for their

comments and observations through a letter dated 19th June, 2019.

7. On spot checks in July 2019 of health facilities' Obstetrics and Gynaecology Department showed that Q.E.C.H received 20 nurses out of which 8 nurses have since left for various reasons, implying need for additional nurses. This means that presently there are 77 filled positions against 65 established positions.

8. K.C.H confirmed that there are 31 new nurses in addition to 38 existing nurses and 9 Interns recruited by the Hospital itself totaling to 78 against a staff establishment of 70. The Interns were recruited to reduce number of locum staff, who are usually the same nurses working overtime without resting.

9. Zomba Central Hospital confirmed that 19 new nurses were recruited. Although this has improved the situation in that there are 63 nurses/midwives in total, there is still need for additional nurses as the existing establishment is 75.

10. Mzuzu Central Hospital confirmed that they have recruited 19 new nurses totaling to 51 nurses against an establishment of 89.

11. The above figures indicate an improvement rate of 48% in terms of the Nursing Section filled positions in central hospitals. It was stated that the central hospitals still require additional nurses to cater for the greater numbers of patients being served, as currently there is an average of 1 nurse to 32 patients against the International Council of Nurses standard of 1 nurse to 6 patients. It was established that there are no new clinicians that have been recruited in all the health facilities and this is posing serious skills gap requiring immediate intervention.

c) Insufficient ward and theatre space for Obstetrics and Gynaecology Department

1. The investigation revealed that there are serious challenges in terms of availability of ward space and theatre rooms in Obstetrics and Gynaecology Departments in some of the central hospitals.

2. Q.E.C.H has 2 functional theatre rooms which can handle an average of 15 surgeries per day. However, there are an average of 35 pregnant women waiting for surgery in a day. It was reported that 70% of the delayed surgeries during the period under investigation were due to lack of theatre space. This therefore means that women have to wait longer to undergo surgery which may result into other complication such as uterus rupture, still birth and even death of the patient. It was reported that Q.E.C.H registered three deaths of pregnant women between January and July 2018 due to lack of theatre space.

3. In as far as ward space is concerned the Obstetrics and Gynecology at Q.E.C.H has a bed capacity of 159 against an average demand of 115 per day.
4. Zomba Central Hospital has 196 bed capacity against an average demand of 145 patients per day.
5. K.C.H has 138 bed capacity against an average daily demand of 80 per day.
6. Mzuzu Central Hospital has 52 bed capacity against an average daily demand of 100 patients per day.
7. Although in some cases the bed capacity outnumbers the patients admitted per day, it should not be overlooked that other patients take some few days before being discharged. As a result, the cumulative number of undischarged patients can exceed the bed capacity.
8. The MoH acknowledged the challenges of limited space in all the central hospitals. Currently, out of the 4 central hospitals only Lilongwe has a district hospital (Bwaila). The existing set up overloads the central hospitals with cases that should have been handled at lower level facilities.
9. As a way of dealing with this problem, MoH stated that they are renovating the Gynecology Ward at Q.E.C.H and that the Medicins Sans Frontiers, France is constructing another theatre at Q.E.C.H. Nonetheless, there will be need for 2 more theatres in order for the Obstetrics and Gynaecology to serve patients better.
10. Besides, the MoH has also started strengthening Community Health Structures (Primary and Secondary delivery service level) by creating theatre space, providing equipment and qualified personnel in order to address congestion problems at central hospitals and access to quality healthcare.

d) Administrative factors

1. In almost all the health facilities there is acute shortage of ambulances and fuel. This contributes to delays in transporting women who develop complications during labour to central hospitals.
2. MoH stated that currently it has procured 78 ambulances albeit not enough to cater for the current challenges because according to World Health Organisation standards 1 ambulance is supposed to serve a population of 50000. As it is, 300 or more ambulances would be ideal to procure for the whole country.
3. Another problem was frequent stock outs of suturing materials without which a caesarean procedure cannot take place.
4. There is also water problem in almost all the health facilities. Q.E.C.H highlighted that the maternity ward and theatre can sometimes go for 8 to 12

hours without running water which is essential for theatre procedures. .

5. The water problem coupled with overcrowding affects general cleanliness of the patients and sanitation of the wards. This is worsened by the fact that there are inadequate number of hospital attendants who are unable to keep up with the required cleaning frequency.
6. Although there are sanitation committees in place that have a responsibility to ensure that the maternity ward is scrubbed twice a week, sometimes it is difficult to follow the schedule due to overcrowding of patients.
7. The Government is currently contracting out cleaning services to private companies, who sometimes perform sub-standard work due to lack of expertise on infection prevention practices.
8. MoH acknowledged the existence of water challenges in some central hospitals and stated that plans are underway to address them.
9. Another challenge is high staff turnover as a result of low salaries which are not commensurate with the huge workload. For instance between June and November 2018 about 10 nurses resigned at Q.E.C.H.
10. Responding to the administrative issue during data collection in 2018, MoH stated that inadequate resources is as a result of insufficient, unpredictable and unsustainable health financing. In order to address some of these issues, the MoH intends to devolve power to central hospitals through a Board of Trustees so that they are autonomous entities that can generate revenue on their own.
11. Our further inquiries early this year established that names of Trustees were nominated and were waiting for approval from the Office of the President and Cabinet to start functioning. The MoH will only have the responsibility of monitoring the standards, quality and provide support in terms of personal emoluments for staff.

e) Administration of antibiotics and lack of medication.

1. It was unearthed during the investigation that all central hospitals administer the antibiotics once to pregnant women undergoing surgery to cover the whole recuperating period. Whilst ordinarily this dosage is supposed to be effective, there has been a growing trend of Antimicrobial resistance (AMR) rendering most commonly used antibiotics redundant in prevention of infection. This may require Malawi to consider elevation of the profile drugs.
2. MoH pointed out that selling of the drugs on the counter is also posing as a big challenge in countering AMR since the antibiotics are sold without prescription despite the controls put in place by the Pharmacy, Medicines and Poisons Board. A number of stakeholders are carrying out awareness

campaigns on AMR and its implications. Nevertheless, it was accepted that there exists other systemic issues that need to be observed in managing infections at the hospital setting.

3. MoH reported that whilst at first the Pharmacy, Medicines and Poisons Act had weak penalties, the newly enacted Pharmacy and Medicines Regulatory Authority Act, 2019 provides for stiffer penalties.

4. MoH decentralized the procurement of drug to central and district hospitals for them to procure drugs directly from CMST. However, MoH informed my office that the main challenge contributing to the unavailability of drugs in hospitals is that Government has not capitalised CMST to readily procure drugs such that when the hospitals place orders, the drugs are readily available. The present situation is that CSMT waits for hospitals to pay for drugs and uses the same payment to procure drugs.

f) Medical factors

1. Eruption of the uterus as a result of delayed elective caesarean section by medical practitioners for patients with previous uterine scars or other medical disorders of either the mother or the baby.

2. Failure by medical practitioners to properly diagnose excessive bleeding after child birth.

3. Where there is uterus infection which is treated and monitored for 48 hours and there is no improvement but the medical practitioner is not taking further medical step (s) to assist the patient.

4. Sometimes delayed labour caused by inaction by the medical practitioner can cause uterus infection where the passage is too small or passenger is too big.

5. If there is delayed referral from the health facility to central hospital, it may result in either stillborn harbouring infection which also affects the uterus or uterus rupture.

g) Cultural factors

1. In some communities it is a taboo for women in labour, to go to the hospital during daytime for fear of being bewitched (masana afiti atiwona). This delay leads to complications.

2. In other areas there have been delays because of the belief that ambulances traveling at night carry blood suckers.

3. Some elderly women in the village administer traditional herbs to accelerate contractions of the uterus before they go to hospital. Once at the hospital the patients are given conventional medication to support delivery in hospitals. The combination of the two may result in the rupture of the uterus as it is overburdened.

h) Patient related factors

1. Some women exercise poor personal hygiene practices, as they do not bathe and wash their clothes when going to the hospital as required to prevent the body from carrying harmful bacteria.
2. Most young ladies who opt for unsafe abortions come with many complications resulting into damaging their uterus. These result into the removal of the same.
3. Patients with weak immune status are prone to developing infection.
4. Malnourished women experience greater maternal morbidity and have a greater risk of poor pregnancy outcomes.
5. Some patients seek medical assistance late when infection is at an advanced stage.

i) Health worker related factors

1. Inaction and lack of care by some health workers which results in prolonged labour leading to maternal sepsis.
2. At times patients are referred to central hospitals in worsened conditions. As a result, these problems are manifested at the central hospitals due to mismanaged cases from the primary or secondary service delivery level facilities.
3. Multiple vaginal examination during labour may cause infection. The examination times should not exceed 5.
4. Some health workers decide to treat the infection other than addressing the source of the infection which is the uterus. This wastes more time thereby worsening the condition of the patient such that by the time the patient is referred to a central hospital, the only option is to remove the uterus.
5. In other cases infection may arise due to the manner in which the patient was prepared before and after caesarean section.
6. During investigations, one of the issues that came to the fore was selectiveness and ineffectiveness of disciplinary proceedings which perpetuates indiscipline of some of the health personnel. For instance, it was stated that there should be proper disciplinary procedures followed when a health personnel is wrong. Besides, when such cases are sent to Headquarters, they should be duly attended to and appropriate decisions made.
7. Currently, most cases which were sent to Headquarters are not being dealt with. Support staff are just being transferred from one place to another yet their cases remain non-concluded. It is high time health personnel are informed of the repercussions of their mistakes in order to deter the same in future.

8. A report from NMCM showed cases that they had dealt with from January 2018 to July 2019. However, it did not disclose the actual steps and outcomes of the cases that they had resolved.

9. Medical Council of Malawi statistics show that for the year 2017 it processed 9 cases and for the years 2018-2019, 10 cases have been determined and outcomes given.

H. ANALYSIS

1. Over and above the Constitution and other local legal frameworks, a number of international instruments which Malawi is a party to such as International Covenant on Economic, Social and Cultural Rights,[2] the Constitution of the World Health Organization,[3] and the Protocol to the African Charter on Human and People's Rights on the rights of women in Africa (Maputo Protocol)[4] affirm the right to health as a socio-economic right.

2. Being a socio-economic right, it means that "the state has an obligation to take appropriate measures for the progressive realization of economic, social and cultural rights," **Chief Justice Misra** wrote. *"The 'doctrine of progressive realization of rights', as a natural corollary, gives birth to the doctrine of non-retrogression."* [5]

3. Many national constitutions, Malawi inclusive have allowed for the progressive realization of some economic, social and cultural rights. This means that Malawi needs to comply with its obligation to take appropriate measures to ensure realisation of these rights in the light of the financial and other resources that are at its disposal.

4. Section 13 of the Constitution provides for a number of guiding principles of national policy for the Government of Malawi aimed at achieving several goals. In as far as health is concerned the Government is obliged to adopt policies and legislation aimed at achieving adequate health care commensurate with the health needs of Malawi Society and international health standards of health care law.

5. Section 30 (2) of the Constitution obligates the State to take all necessary measures for the realization of the right to development. One of the aspects of the right to development is the right to access basic resources such as health services which includes Obstetrics and Gynaecology treatment.

6. Despite all these regulatory frameworks resulting in some success stories here and there, maternal mortality and morbidity still haunts Malawi which in

[2]Article 12(1)
[3]The preamble and article 1 of the Constitution
[4]Article 14(2)(b)
[5]https//www.thehindu.com

2016 stood at 439/100000.

7. Coupled with this problem is that of an increase in hysterectomies which based on reports and this investigation are being caused by a number of preventable factors.
8. As stated above the primary responsibility to provide quality health care falls on the State. Other than coming up with the legal and policy framework, the State is supposed to actually set aside sufficient resources to deliver quality health care in line with the legal and policy undertakings.
9. Legally, the Government of Malawi is supposed to provide enough resources to ensure there is enough staff, enough facilities like wards, theatres, ambulances and medication within the health services commensurate with the health needs of the country. However, one needs to simply visit any public hospital in the country to appreciate how much the State is failing its people in this regard.
10. The situation becomes more delicate with Obstetrics and Gynaecology because at this point the system is not only dealing with a life of one but two.
11. Due to inadequate transportation, there is delay in sending pregnant women to central hospital from a local facility.
12. Further delays may happen at a central hospital to take a patient to the theatre room due to lack of theatre space. Other contributing factors to the delays might be availability of qualified personnel, medical equipment such as suturing materials and gas cylinders. This has created a more serious situation beyond the hysterectomy as the investigation has shown that some deaths occurred at Q.E.C.H due to lack of theatre space.
13. Whilst the stated Government efforts are appreciated in as far as staffing is concerned, my inquiries have proved that as of the date of this report the central hospitals especially the Obstetrics and Gynecology have only received 98 additional health nurses personnel, 8 of whom have since resigned within a period of 5 months. This is still way below the required numbers of personnel.
14. In some instances, it was noted that there was discrepancy between established and filled positions in that some filled positions have outnumbered established positions. On the outset, this gives an indication that there is more than enough medical officers to cater for a given catchment area. However this is not the case as even in such health facilities, staff challenges were still observed. All it means is that staff establishments for these health facilities were developed and adopted some time back and do not speak to the present demand of the country in general and a catchment area in particular.
15. These staff shortages have indeed seriously contributed to patients contracting maternal infections, prolonged illness, missing timely administration of medicine

and even death.

16. The situation is worsened where specialist treatment is required but the specialists and anesthetist are not available. Patients have no choice but to wait for long periods before being attended to. In the process of waiting, some tend to develop complications, which could have been avoided.

17. It was noted that maternal sepsis is sometimes exacerbated by shortage of drugs like the necessary antibiotics in the hospitals. Although the MoH has decentralized procurement of drugs to the Councils, this has not fully solved the problem at all, as shortage of drugs has continued in central hospitals. One of the reasons for this scenario is that funds meant for drugs have been used for other activities. For example, Zomba Central Hospital pointed out that drawing funds from the pool funding at District Council has negatively affected provision of health services in that the funds are diverted to other services by the office of the District Commissioner. Failure to prioritize health issues in this manner has serious negative impact on the delivery of health services.

18. It was further observed that regular running water interruption is one of the contributing factors to maternal sepsis at Q.E.C.H. Despite numerous discussions between Q.E.C.H and Blantyre Water Board, the problem remains unresolved. Whilst appreciating the infrastructure challenges with the water pipes, according to the report from Blantyre Water Board, Q.E.C.H has not been vigilant in its plumbing repairs.

19. Over and above all these problems, it cannot be denied that there is neglect of duty by some medical personnel. Most of the complaints that my office received after the Zodiak report point to medical personnel especially the nurses failing, refusing or neglecting to take an action or attend to pregnant women when the situation so demands. Unfortunately this has resulted in irreversible damage in form of hysterectomies and even death

20. The very nature of health service delivery especially in public health facilities puts the patient in a highly compromised position due to the following factors: firstly, when one seeks medical attention, it is a matter of life and death and it is the medical personnel dangling that life and this puts the patient in a subservient position; secondly, it is largely people from rural areas and those from lower levels of the social strata who visit public health facilities. This situation further pronounces their vulnerability when accessing health services. Because of this, cases of negligence and other malpractices by medical personnel are never pursued by the victims and therefore culprits go unpunished and systems remain uncorrected. This is also evident even in the individual experiences highlighted in Paragraph A that were submitted to my office in response to the request, as none of the individuals had ever complained before any

tribunal for redress. Some wanted to sue but hesitated as they did not want to relive the ordeal. Others although angry with the system simply resigned to their fate.

21. From the information that has been provided by NMCM it is difficult to conclusively determine whether or not their processes are effective.

22. In as far as cases against the clinicians are concerned, it appears that the Medical Council of Malawi is effective in disciplining them and have meted out a range of punishments from warning to striking out on the role of practicing clinicians. In regard to medical doctors, it was noted that there are few cases against them. Even on the few cases, the finding was that it was the hospital itself which was at fault.

23. From the few statistics provided by Medical Council of Malawi as well as NMCM in relation to the number of health facilities in the country, the numbers demonstrate that either people are being satisfied with the services of clinical officers and doctors or that they do not know where to complain or indeed people have resigned to their fate as already alluded to in paragraph H (20) above.

24. Furthermore, efforts to enforce accountability in health services through the Hospital Ombudsman platform which my office in collaboration with the MoH itself has been advocating although getting enough support on the podium and paper, continue to suffer resistance from some of the health personnel themselves.

25. In as far as the patient related factors are concerned, there are sporadic interventions such as by-laws in local authorities that encourage women to go to hospital in time. In some localities, there is established a fee that needs to be paid by every woman who delivers outside a health facility.

26. Through my office's mobile clinics, it has been observed that the intervention is effective especially in areas where there is political will by the Local Authority. It was further observed that some women are still reluctant because of the general treatment they receive when they go to the hospital they would rather seek assistance from traditional birth attendants.

27. Minus the medical and the personal patient factors, the hysterectomies that are being carried out in the central hospitals are motivated by factors that speak to a failure of a system or indeed malpractice of the health personnel themselves.

I. SUMMARY OF KEY FINDINGS

Having fully investigated the allegations levelled against the health facilities, I have established that there are acts of maladministration in the manner in which health facilities are providing maternal health services. The following are my findings:

1. The MoH has failed its duty to provide sufficient staff to cater for the needs for Obstetrics and Gynaecology Departments in all health facilities resulting in compromised quality service delivery in the country. Moreover, in other health facilities where the MoH appears to have exceeded the staff establishment, the same has been found to be largely insufficient in reality to meet the actual demand within the catchment area clearly showing that such staff establishments are outdated.
2. There is insufficient ward space, beds and theatres in some central hospitals in the country resulting in delays in assisting patients as well as compromised sanitation in the wards, both of which have contributed to the increased number of maternal infections and attendant uterus raptures in some instances. This has contributed to the number of hysterectomies and even resulted in deaths. It is the obligation of the Government to provide these to its people. Failure to provide the same amounts to breach of duty by MoH.
3. Shortage of drugs and medical equipment is a common feature in the health system in the country and the sad part is that despite this being a serious issue it is no longer alarming, it has become part of our lives. However, fact remains that this problem affects real people. In Obstetrics and Gynaecology the stakes are high because there are two lives involved and where hysterectomy has been conducted it is not only the social cultural standing of the woman that is affected but the country's potential demographics as well.
4. Common occurrence of shortage of drugs in the hospitals speaks to systems failure and neglect of duty. Whilst this may not be a representation of the whole country, our investigations revealed that there is a problem of inadequate or no drugs in some lower level health facilities, which are meant to increase accessibility of health care and reduce congestion in central hospitals.
5. The very fact that there is a bypass fee is an acknowledgement that the structures that are in place are not working to the satisfaction of health service users at lower level health facilities. This points to the fact that the said medication that is supposed to be available at lower level health facilities are not even there.
6. Shortage of ambulances and/or fuel in most of the health facilities contributes to the delay of transporting emergency Obstetrics and Gynaecology patients

to referral hospitals for immediate medical attention. This also results in worsening of the condition such as uterus rupture of the patients leading to either hysterectomy or death. Failure to provide ambulances/fuel is an omission of duty on the part of MoH.

7. Most of the disturbing incidents of hysterectomy are those arising from pure negligence and lack of care on the part of health personnel. This as it may, only few of such medical personnel are held to account for their misconduct. Due to their socio-economic status the majority of patients do not feel empowered enough to speak out thereby obliging the MoH to put measures to protect them. Whilst some strategies have been put in place, the same are not far reaching and are/or subjected to heavy resistance and defensiveness from the health personnel themselves. The failure by the MoH and Regulatory Bodies to effectively hold such health personnel accountable for their actions is unreasonable, unfair and amounts to maladministration.

J. UNINTENDED FINDING

8. Q.E.C.H has a lot of water leakages due to obsolete water pipes, which the MoH has neglected to repair. The leakages are contributing to low pressure of running water and in turn affecting general cleanliness of the hospital with high stakes for Obstetrics and Gynecology sections.

K. INJUSTICE OCCASIONED

Health facilities should ordinarily be safe environment where good health and life is preserved. It is the State's obligation to provide quality health care to its citizens. Non availability of resources to provide the basics like enough personnel, medication and other resources should not be an eternal excuse for State's failure to provide basic health care. Where such failure results in serious situations like avoidable hysterectomies as in the instant case then it becomes a national tragedy requiring non-traditional intervention. Anything outside this is injustice.

L. REMEDIAL ACTIONS

1. Under section 126 of the Constitution and section 8 of the Ombudsman Act, I am empowered to direct an appropriate administrative action to be taken to redress the grievance and also cause an appropriate authority to ensure that there are in future reasonably practicable remedies to address the grievance.

2. In short, the law gives me powers to remedy the injustice occasioned as explained above. From the foregoing, it is my view that the injustice occasioned can only be remedied by way of systemic intervention as outlined below:

c) Short-term interventions

1. MoH to engage with Ministry of Information, Civic Education and Communication Technology to popularize the contents of Pharmacy and Medicines Regulatory Act, 2019 with particular emphasis on the penalties for contravening its provisions. The popularization should target the general public and also Prosecutors, Magistrates and Private Pharmacies. Further, the collaboration should work on disseminating information contained in the National Community Health Strategy (2017-2022) which aims at ensuring that health services are accessible and patient-centred. I direct that a report should be submitted to my office by 31st January, 2020.

2. Q.E.C.H should carry out plumbing maintenance at the hospital which will eradicate leakages and also reduce low water pressure problems. This should be done by 31st January, 2020.

3. Q.E.C.H in consultation with Blantyre Water Board should explore the possibility of having dedicated water supply line in order to curb the current water supply shortage. A report of the resolution should be submitted to my office by 31st January, 2020.

4. I strongly recommend that the MoH and the regulatory bodies should vigilantly and impartially discipline all health personnel guilty of acts of misconduct in order to deter other medical personnel from negligently conducting their duties.

d) Long term interventions

5. MoH having assessed its existing staff establishments of doctors and nurses in all health facilities and considering that the functional review process is at an advanced stage, I direct that this process should be finalised by 30th June, 2020 and a report furnished to my office.

6. In my report titled *"Out of Sight, Out of Mind"* released in December 2017 I had directed the Secretary for Health to facilitate a review of existing physical structures of its district hospitals by March 2018 in order to assess the possibility of establishing mental unit. During this investigation MoH acknowledged that the assessment has been done and that it has covered all areas of health care including Obstetrics and Gynaecology awaiting construction/expansion of its facilities. In light of the steps already taken and efforts to strengthen the already existing facilities and renovations at Q.E.C.H Chatinkha Maternity Wing and the additional theatre under construction by Medicins Sans Frontiers, France, I direct that budgetary allocations should start from 2020/2021 financial year and the constructions and renovations should be done by 2025.

7. In compliance with the Abuja Declaration, 2001, that requires all parties to ensure that 15% of the annual national budget should be allocated to the improvement of the health sector, it is strongly recommended that Malawi complies with this obligation by 2022. This will effectively resolve some of the problems relating to financial resources considering that the right to health is a socio-economic right, whose obligation is placed on the State to achieve progressively. In addition, the District Commissioners should ensure that funds meant for the health sector are utilized for their intended purpose.

8. CMST being the source of pharmaceutical supplies in public hospitals, should be one of the most prioritized Institutions to be well funded by Malawi Government, as its system failure negatively affects a larger population of Malawians. It is therefore recommended that Treasury should increase and prioritize funding to CMST to ensure round-the-clock availability of pharmaceutical supplies.

Dated this 22nd day of August, 2019.

Martha Chizuma
OMBUDSMAN

LIST OF PEOPLE CONTACTED DURING INVESTIGATIONS

	NAME	DESIGNATION
1.	Dr. Dan Namalika	Secretary for Health
2.	Dr. Charles Mwansambo	Chief of Health Services
3.	Dr. Andrew Likaka	Director of Quality Management
4.	Dr. George Chithope Mwale	Director of Clinical Services
5.	Dr. Phylos Bonongwe	Head of Obstetrics and Gynaecology (Q.E.C.H)
6.	Dr. Luis Gadama,	Gynaecologist, Academic Head of Department (Malawi College of Medicine)
7.	Ms Tulipoka Soko	Director of Nursing and Midwifery Services
8.	Ms Kate Langwe	Director of Planning (Ministry of Health Headquarters)
9.	Mrs. Jocelyn Masamba	Deputy Director of Human Resources
10.	Mr. Burton Katantha	Chief Human Resource Management Officer
11.	Dr. Kelvin Mponda	Deputy Hospital Director (Q.E.C.H)
12.	Ms Edith Tewesa	Senior Nursing Officer (Q.E.C.H)
13.	Ms Chewere	Deputy Hospital Director Nursing and Midwifery Services (Q.E.C.H)
14.	Mr. Themba Mhango	Chief Hospital Administrator (Hospital Ombudsman for Q.E.C.H)
15.	Mr. Samuel Tamaks Mbewe	Senior Assistant Human Resource Management Officer (Hospital Ombudsman for Blantyre District Health Office)
16.	Dr. Kalawazira	Blantyre District Health Officer
17.	Dr. Jonathan Ngoma	Director of Hospital Services (K.C.H)
18.	Dr. Priscilla Phiri Mwanza	Deputy Head of Department for Obstetrics and Gynecology (K.C.H)
19.	Mrs. Hlalapi Kunkeyani	Chief Matron (K.C.H)
20.	Mrs. Mable Chinkhata	Deputy Hospital Director for Nursing (K.C.H.)

21.	Mr. James Mbewe	Senior Medical officer (Bwaila District Hospital)
22.	Dr. Doris Kayambo	Head of Department of Obstetrics and Gynaecology, Obstetrician and Gynaecologist, Principal Specialist
23.	Mr. Tom Chisale	Chief Hospital Administrator (Zomba Central Hospital)
24.	Dr. Raphael Piringu	District Health Officer (Zomba District Health Office)
25.	Mrs Esther Chiphwanya	Human Resource Management Officer (Bwaila District Health Office)
26.	Ms Charity T. Kasawala	Deputy Hospital Director (Nursing and Midwifery) (Mzuzu Central Hospital)
27.	Mrs. Joyce Beyamu Muhota	Acting District Nursing Officer (Bwaila District Hospital)
28.	Dr. Ethel Rambiki	District Medical Officer (Bwaila District Hospital)
29.	Dr. Frank Sinyiza	Director of Hospital Services (Mzuzu Central Hospital)
30.	Joe Khalani	Acting Director of Pharmaceutical Operations (CMST)
31.	Dr. Isabella Musisi	Registrar (Nurses and Midwives Council of Malawi)
32.	Mrs. Chrissie Chilomo	Director of Examination and Registration (Nurses and Midwives Council of Malawi)
33.	Mr. Richard Ndovi	Acting Registrar (Medical Council of Malawi)
34.	Melody Wandidya	Senior Inspections Officer, (Medical Council of Malawi)
35.	Emmanuel Bande	Zomba District Commissioner
36.	Mr. B.F Nkasala	Blantyre District Commissioner
37.	Mr. Emmanuel Bulukutu	Karonga District Commissioner
38.	Ms Rosemary Nawasha	Mchinji District Commissioner

39.	S. Gwedemula	Ntcheu District Commissioner
40.	Memory Kaleso	Phalombe District Commissioner
41.	Charles Mwawembe	Salima District Commissioner
42.	Mr. Cohen M. Choso	Deputy Director for Organisation Development (Department of Human Resource Management and Development)
43.	Mr. Bright Mziliwanda	Distribution Manager (Blantyre Water Board)

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