Medical care in Africa in 2020 with COVID 19.

"Thank God WMF are still here because everyone else has disappeared…".
June 2020, the words of the District Health Officer Nkhotakota to our Chief Clinical Officer.

We were able to continue our work because we were granted an export licence for PPEs (overcoming the E.U. ban on their export). This meant we were able to ship quality protective items including face shields and masks that were unavailable in Malawi. This meant our team could continue our life-saving work with the mobile clinics with their own safety ensured.

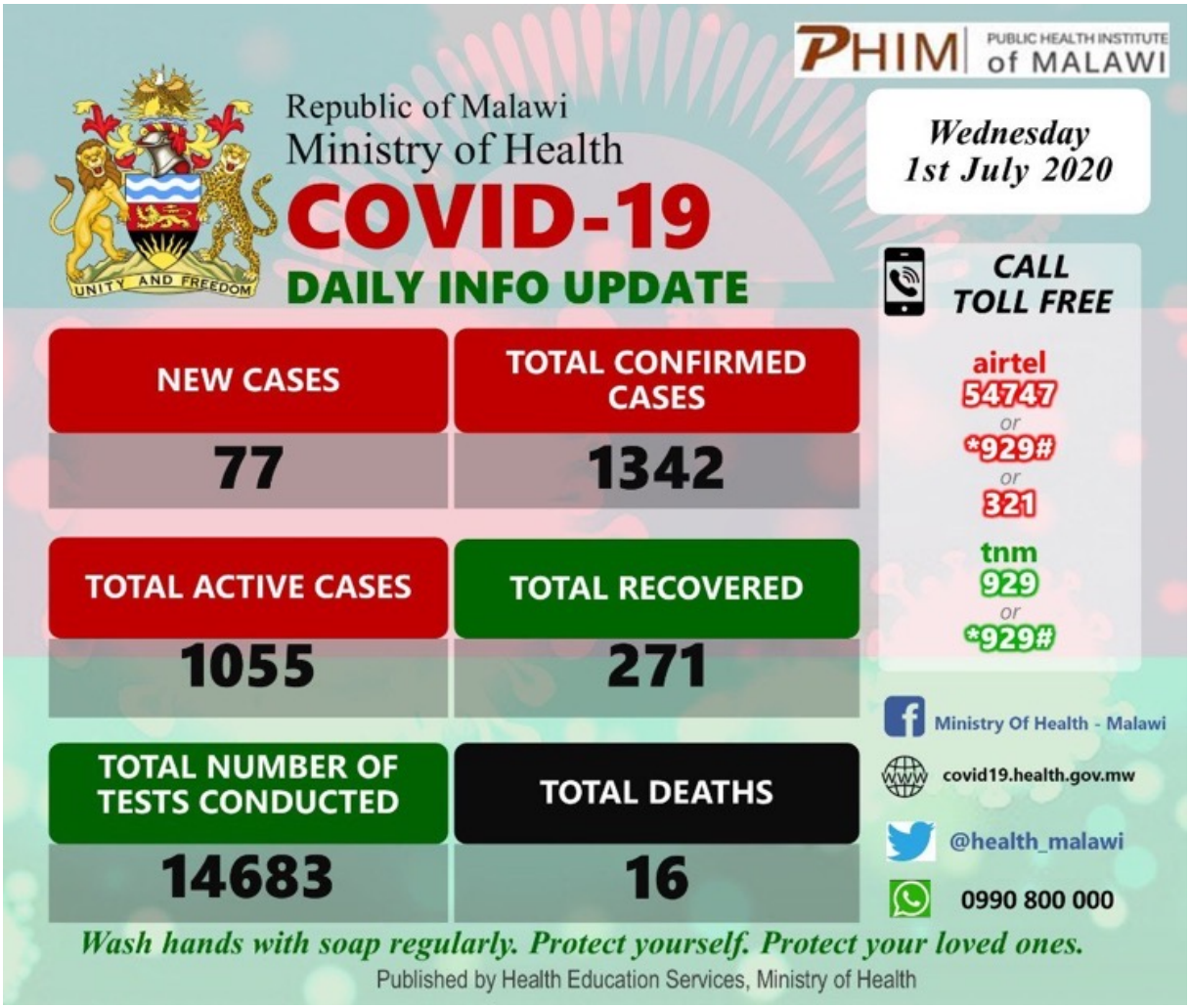
Our clinicians have chosen to use hand sanitizer between patients, rather than wear and have to change gloves between patients all day long.

2019/20 Report for

Fondation Eagle

world medical fund for children

Registered charity 1063756 in England & Wales and SC046207 in Scotland



Little did we know when we applied for this grant that the world would change forever with the arrival of the COVID-19.

Fondation Eagle reference: 487 - 08

Name of charity: World Medical Fund for Children

Introduction:
The grant was for £46,784, received on the 27th June for the Children's Mobile Clinic 2019.

The location: Nkhotakota district, Malawi.

Duration: A one-year project, approved on the 14th June 2019.

Details of the project:
Following discussions with our trustees we took the decision that our first priority had to be to protect the safety of our clinical team. To that end we stopped our mobile clinics for three weeks to give us time to design a modus operandi that protected the medical team and the patients.

We are most fortunate to have an expert board made up of four medical doctors and two medical scientists, all experienced at working in sub Saharan Africa. By putting our heads together we came up with a “Hot” and “Cold” system in. which beneficiaries are triaged by a nurse in full PPEs and a non-contact thermometer. The nurse checks their temperatures and asks a set of questions to determine the risk of the beneficiaries being infected with the coronavirus.

The beneficiaries would then be designated “Hot” or “Cold” and the appropriate methodology employed; I am pleased to report it is working well.

Medicines: the grant enabled us to purchase vitally needed medicines to treat up to 45,000 sick children. In 2020 we applied for and were granted permission to use part of the funds designated for medicines for PPEs and protective measured for our staff.

Our Children’s Mobile Clinics are the only realistic access to medical care for children in the villages far from the tarmac road and every year it saves many young lives.

Clinical Officer: We advertised for a new Clinician and received a good response. We were most fortunate to have one of our UK medical advisers (a General Practice partner) in Malawi on a monitoring visit so he was able to join our Malawi team for the interviews.

One of the candidates stood out from the rest, Benjamin was a really good match for what we do as he holds a specialist’s qualification in Paediatrics as well as his Diploma in Clinical Medicine.

His previous experience combined academic research with the delivery of medical care. This is important to us because as well as being an excellent clinician, he is an accomplished report writer and provides us with weekly case studies.

Whilst we were going through the three-month recruitment process to find Benjamin we had a piece of good fortune. Abdul who had just graduated as a doctor at the Malawi medical college came to see us, he informed us that he was awaiting his posting as an intern so asked if he could volunteer with us. This is the first time in our history that one of these newly qualified Malawi doctors had volunteered to spend this time with us and he became a great asset in the three months he spent with us.

He told us “I am from Nkhotakota and as a young boy I would see the World Medical Fund vehicles going off to treat sick children and save young lives in the villages – that truly inspired me and I swore that when I grew up I would train to be a doctor and work for this organization. I have now fulfilled that ambition.”

Abdul has been in contact with his medical college with the aim of making this an annual event for newly qualified Malawi doctors and will remain in contact with WMF.

Child Cancer Patients: We received funds for 26 child cancer patients to be referred to the child oncology unit in Lilongwe we have established a relationship with.

We found that with the political unrest and continued violent demonstrations in the early part of the year in Lilongwe there was a certain reluctance from parents and guardians to travel to the capital. In total there were just 11 beneficiaries, one of whom is sadly at a terminal stage and receiving home-based palliative care from our team.

Lessons learnt:

Adapting to unprecedented and unexpected challenges; fortunately we had contingency plans in place for an epidemic (expecting it to be Ebola).

Project beneficiaries:

The world has changed, whether it will ever return to what we knew is impossible to say. It is probably true to say we are unlikely ever to return to the days when we treated over 500 sick children in one day. With 34,545 beneficiaries in the last twelve months, the Mobile Clinic saw a drop in numbers treated down for the first time in living memory, due to the following factors:-

- With the arrival of the COVID-19 we stopped the clinic for 3 weeks to give us time to design a protocol to ensure our staff could work safely and to acquire PPEs for their protection.
- Throughout the year we have an average of 4 final year medical students/newly qualified doctors who choose to spend their medical electives working with us and play an important role in the delivery of our programme. That had to end in the middle of March 2020 with the last group having to leave abruptly before the borders closed.
- The “Hot” & “Cold” protocol we now employ to pick up those beneficiaries at high risk of being infected with COVID-19 slows down the pace of the clinics but it is an essential part of our work now.

The most common conditions we treated over the last twelve months are Malaria (27%), Respiratory Tract infections (18%), Eye infections (5.5%), Dysentery (Bloody diarrhoea) (4.6%) and Bilharzia (4.0%).

Further Progress of the project:

The delivery of medical care always involves striking a balance between quality, cost and quantity.

When we began our mobile clinic 18 years ago it was intended to save young lives in large numbers with a protocol of bringing access to basic primary care for acute conditions and not to take on the care of chronic (long-term) conditions.

Our board of medical advisers (made up of 4 medical doctors and two medical scientists) have taken the decision that the time is right to make changes to that protocol. We are going to increase the quality of the medical care we provide and the mobile clinic now carries an Ultrasound device, an ECG Machine, a haemoglobin meter and an examination couch.

What this means is we now deal with more complex cases, there are more referrals for in-patient care with follow up by our team. It will allow our medics to spend more time with each beneficiary, doing in-depth investigations. Whilst there may be fewer beneficiaries and the cost per case will rise, effective triage will ensure that every urgent or serious case is seen.

Expenditure summary (as at July 1st 2020):

Title	Grant	Expenditure	Balance	
Medicines	37,819	37,955	-136	Overspend
Clinical Officer	5,897	5,463	434	Underspent
Children Cancer	3,068	2,108	960	Underspent
		Total: =	1,258	Underspent

Our request for the underspend is to put it towards the purchase of a Phillips "Simply Go" portable oxygen concentrator. We expect children with serious breathing difficulties to present at our mobile clinics (because of COVID-19) and this lifesaving device will give us a chance of keeping them alive until we can get them to hospital; the cost is £2,100.

Medicines and PPEs.

Supplier	Date	Amount Mk	Total in £
Medisave	10/06/2020		109.98
Pharmavet	09/06/2020	500,625	545.34
Medisave	01/05/2020		91.25
Pharmavet	30/04/2020	495,275	539.52
Pharmamed	27/04/2020	55,000	60.43
Medisave	17/04/2020		272.87
Medisave	17/04/2020		185.63
Pharmamed	08/04/2020	196,000	213.51
Ebay	07/04/2020		98.06
Durbin plc	26/03/2020		215.75
Pharmavet	15/02/2020	10,841,455	11,809.86
Pharmavet	07/11/2019	269,500	293.57
Durbin plc	16/09/2019		282.5
Pharmavet	26/08/2019	13,826,100	15,061.11
Pharmavet	13/07/2019	244,000	265.80
Pharmavet	03/05/2019	7,261,300	7,909.91
TOTAL			**37,955.09**

The calculations are made with an exchange rate of 918; the exchange rates varying from 871 to 956 on the dates of the transactions and 918 is the balanced mean and coincidentally happened to be the day rate quoted for the date of this report.
We purchased a range of over 60 medicines, mainly antibiotics in capsule, pill and ampoule form (for injection). For Personal Protection Equipment we purchased face shields, face masks, gloves and gowns.

Results:

The last twelve months they have certainly been a challenge - but the most important thing is the mobile clinic is back to continuing its vital work, saving young lives.

Conclusion:

The grant from Fondation Eagle was vital to us and it made it possible for us to continue saving young lives during these difficult times.

The work goes on, Dr Abdul

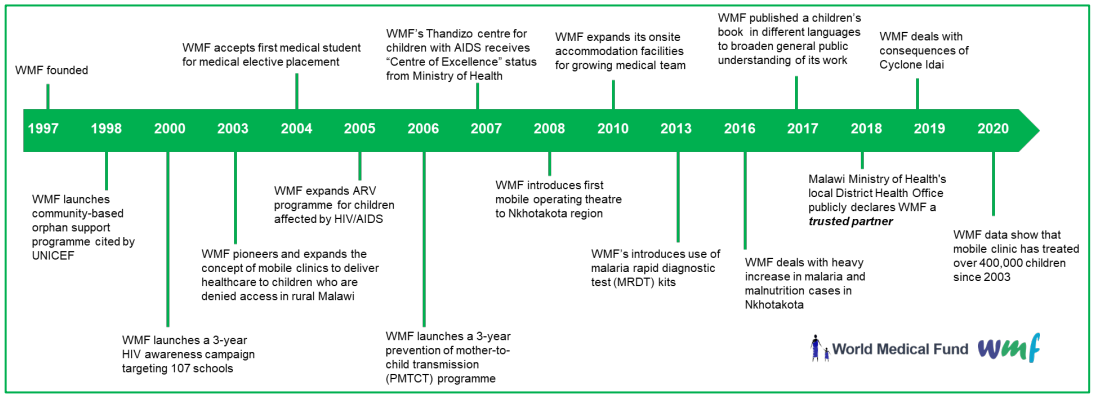
The work goes on, Chief Clinical Officer Martin

Where we work:

REGIONAL DEMOGRAPHICS	
Population	430,507
Aged under 15 years	206,643
Aged under 5 years	73,186
Aged under 1 year	21,525

Source: District Health Office data passed on to Malaria Control Unit in Lilongwe

Since 2003, WMF has treated over 400,000 sick children through all its programmes, no easy task, given that the charity relies entirely on external donations.



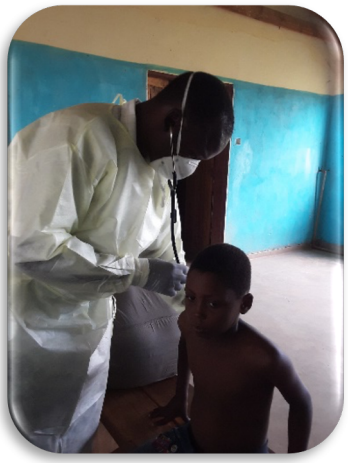
Selected highlights in WMF's history.

Key objectives	1. Combat disease threats and debilitating conditions	2. Strengthen healthcare capacity and access to healthcare	3. Improve medical and social understanding of Malawi's challenges
Strategic approach	Deliver healthcare using Mobile Clinics and Thandizo Centre of Excellence HIV/AIDS Centre	Develop sustainable solutions for priority areas	Effective partnerships to drive healthcare improvements

Table 1: WMF's approach for sustainable healthcare solutions

A REALLY INTERESTING CASE:

This is 11 years old boy and my diagnosis is he has Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency.



We saw the boy at Kaongozi clinic site on the 18th March 2020 and again on 24th April 2020. He complained about headache, abdominal pain, back pain, passing dark urine and his grandmother noticed paleness in Emmanuel's palms and conjunctivae.

His health passport book had history of several previous hospital admissions. He received 19 blood transfusions in the past. The last time he received blood was on 24 December 2019.

Sickle cell had been suspected and he was tested on five occasions but was negative on all those times.

Physical examination revealed palmer pallor and conjunctival pallor, he was afebrile with temperature of 36.9°C and no organomegaly.

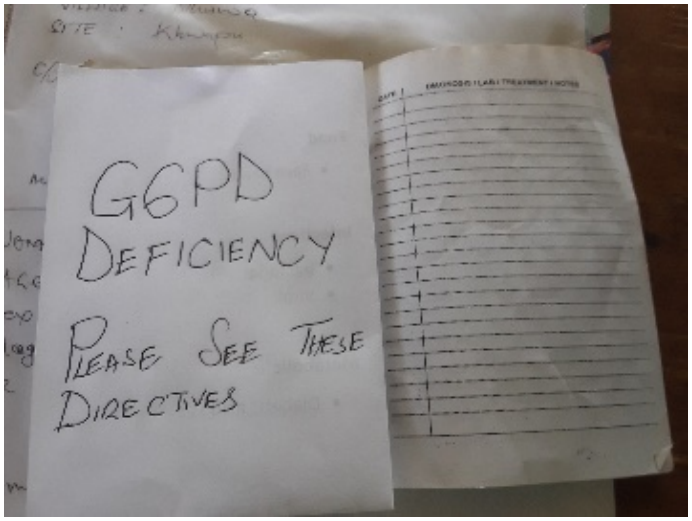
The grandmother said that every time her grandson has fever, he needs blood transfusion and giving him antimalarials seems to worsen the problem.

It is our view he was misdiagnosed on a number of occasions in the past and was given medications which are contraindicated to those who have G6PD deficiency.

Whilst we do not have access to a laboratory able to perform G6PD enzyme levels, Full Blood Count, serum haemoglobin test and reticulocyte count we are confident in our diagnosis.

This is a condition that will rarely be diagnosed in our setting and it's management is a challenge, so what we have done is to make sure the patient and grandmother know to avoid the drugs, chemicals and food that worsen this condition.

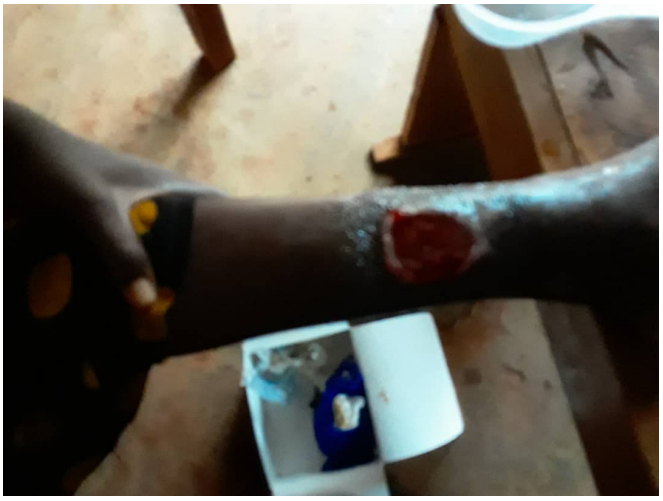
We also entered a warning to other clinicians who may not recognise this condition in large letters in his health passport book.



A CASE STUDY

A twelve-year old girl presented on Tuesday, 05th November 2019 with history of a wound on her leg for one year which started as small cut, injured with a stick when playing with friends.

In the initial stage the cut appeared to start healing however after two weeks she noted that the wound started oozing pus and she could feel pain from inside the wound. She squeezed some pus from the site and relaxed for some days until she observed that the wound was increasing in size.



She did not report any loss of sensation, loss of power nor loss of function on the affected limb. No family history of diabetes mellitus, epilepsy and no history of psychiatry in the family.

PHYSICAL EXAMINATION

Fully conscious with Glasgow Coma Scale of 15/15, Temperature of 37.3°C, Respiratory rate of 22/minute and Pulse rate of 88/minute. Pink palms and pink conjunctivae. Well hydrated and fairly nourished. No jaundice, no skin rash and no oedema elsewhere. **CHEST:** symmetrical expansion, clear lung fields and normal heart sounds. **ABDOMEN:** Soft, flat and no tenderness. **LOWER LIMBS:** normal tone, power of 5/5, normal reflexes, normal sensation and normal gait. **LEFT LOWER LEG:** Big wound measuring about 5cm X 4cm and in a form of an erosion with raised edges on the Shin of her left leg. The wound was filled with a wet gangrenous slough.

SUMMARY

12-year-old girl, HIV status unknown, presented with one-year history of having a septic wound. On examination, she had a big septic wound on her leg.

DIFFERENTIAL DIAGNOSES

1. Tropical Phagadenic Ulcer
2. Pyogenic Ecthyma
3. Chronic non-specific ulcer

INVESTIGATIONS

1. HIV test

MANAGEMENT

TREATMENT GIVEN

1. Wound cleaning with EUSOL (Edinburg University Solution of Lime) to remove necrotic tissue under local anaesthesia (See images on page 5)
2. Metronidazole 400mg TDS for 7 Days
3. Ibuprofen 400mg TDS for 5 days

CARE AT HOME

1. Daily wound cleaning and dressing at the nearest health facility

2. Guardian was given savlon, gauze and bandages to continue wound cleaning and dressing at home. Basic instructions of wound cleaning and dressing were given to the guardian.

DISCUSSION

The girl under this discussion has a condition which causes discomfort especially to school going children like her. She can't stay comfortable among her friends as the wound produces an unpleasant smell. She has a disease called Tropical Phagadenic Ulcer which develops mainly due to poor sanitation. A certain study conducted in four countries which included Zambia, the country that neighbours with Malawi showed that most cases of this ulcer were seen in rural, poor social economic areas and in children or teenagers (1). The condition can also complicate to serious diseases which can cause her to lose her leg. It can progress to either osteomyelitis or squamous cell carcinoma (2).

The outreach clinics conducted by World Medical Fund for Children (WMF) accomplishes wonderful job of helping such underprivileged children. The girl comes from a poor family that struggles to earn a living. The burden she has of the chronic ulcer just made difficulties in her life worse. Poor hygiene as one of aggravating factors of this condition seems to have contributed in her case as well.

RECOMMENDATIONS

In order for WMF to help this girl fully, we need to put follow-up measures in place. This can be achieved by strengthening our site volunteers. We need to equip them with some basic nursing skills like proper wound cleaning and dressing. We need to make sure we maintain good communication between the volunteers and mobile team. This can help the mobile team to know how far the wound healing is progressing and know what type of medications and supplies to prepare for her when preparing for the outreach visit for the site near her.

Benjamin A; Paediatric Clinician.

The Mobile Clinic – a full case study.

BACKGROUND INFORMATION

Name	GD
Sex	Male
Date of birth	17 June, 2017
Age	2 Years and 4 months
HIV Status	Negative
Clinic Site	Kachere
Date	07th January, 2020
Source of information	Patient's Mother
Home Address	Kachere, TA Kanyenda, Nkhotakota District.

PRESENTING COMPLAINT

Vomiting for 3 days, diarrhoea for 3 days and general body weakness for a day.

HISTORY OF PRESENTING COMPLAINT

The child was completely well until 3 days prior to the date MFC team (Medical Fund for Children) went to Kachere for out-reach clinic on 07th January, 2020. The first sign observed by his mother was vomiting which was noted for the first time in this illness in the morning on Sunday of 05th January. He vomited twice that morning and in total on that day he vomited four times. On the following day he vomited six times but on the day we saw him he vomited once since sunrise. He could vomit the food or water he took. There was no blood in it and vomiting was not projectile. On the night of the day he started vomiting he was also observed to have started passing watery stools. Diarrhoea worsened on the next two days when the frequency progressed to 5-6 times each day. The colour of watery stools was like rice-water as described by the mother. There was no abdominal pain and no blood stools reported. No abdominal distension and no fever was noted. The child stopped breastfeeding two months ago.

REVIEW OF OTHER SYSTEMS

Genital-Urinary Tract: Was passing urine and on the day we saw him he had passed it three times.

Central Nervous System:

No convulsions.

PAST MEDICAL HISTORY

No previous hospital admission and no major medical illness.

FAMILY AND SOCIAL HISTORY

The child is the third born child in the family of 3 children. His father is a fisherman and his mother is a housewife. They live ashore of Lake Malawi in a community where sanitary conditions are poor. They draw drinking water from unprotected wells and they practice poor human excreta disposal in the vicinity to the lake as many of them do not have pit latrines.

PHYSICAL EXAMINATION

Generally, he was lethargic though his Blantyre Coma Score was 5/5. Temperature of 36.6ºC, Respiratory rate of 34/minute and Pulse rate of 148/minute. Blood Pressure was not measured. Had pink palms and pink conjunctivae. **Hydration Status**: Was lethargic, Had sunken eyes (See pictures on page 5), skin pinch was going back slowly and was drinking eagerly when he was offered water to drink. No jaundice, no skin rash and no oedema elsewhere. **CHEST:** symmetrical expansion, no basal

crepitation and no deep breathing. Heart sounds were normal. **ABDOMEN:** Soft, flat, no abnormal masses and no tenderness.

SUMMARY

2 years and 4 months old boy, HIV status negative, presented with history of diarrhoea and vomiting for 3 days and a day of body weakness. On examination, he had signs of severe dehydration.

DIFFERENTIAL DIAGNOSES

Acute Gastroenteritis with Severe Dehydration
Cholera.

INVESTIGATIONS

2. mRDT = Negative.

MANAGEMENT

NOTE: According to WHO (World Health Organization) treatment guidelines for severe dehydration, this child needed to be admitted and given Intravenous fluid therapy. The site where we saw this child was at about 13km to the nearest health facility. Transferring him to that health facility right at that time would be risking his life. We came up with an idea of stabilising him first and decide about referral later.

Hence, he was given the following:

- We created Oral Rehydration Therapy corner (ORT corner)
- Oral Rehydrating Salt (Thanzi ORS) 645mls for 4 hours
- Frequent reviews were done during that rehydrating period

Just after 1 hour he was able to call his mother and sunken eyes were improving

- We continued with oral rehydration
- Continued with frequent reviews

After 3 hours since he started ORS

- He was able to sit up by himself and could hold a cup of Thanzi ORS and drink from it.

After 4 hours on ORS

- No diarrhoea nor vomiting was reported since ORT was commenced
- He was still able to sit unaided and could continue to drink ORS by himself
- Hence, the mother was advised to continue giving 100mls of ORS after each loss at home and be prepared to report at the nearest health facility if diarrhoea and vomiting becomes profuse again.
- Zinc 20mg once daily for 10 days was given


DISCUSSION

This 3-year-old boy needed intravenous fluid therapy as per guidelines. What we did to save his life wasn't deviation from guidelines as we were in hard-to-reach area and transferring him to the health centre would put his life at a greater risk of death. He was severely dehydrated evidenced by signs of lethargy and sunken eyes (1) His mother admitted that she could have already taken the child to the health centre if the centre was close to them. This means she could have difficulties to get her child receive medical attention if we did not conduct the clinic in her area on that day. When managing his condition, we took infection prevention precautions like hand washing before and after assessing him, we also isolated him to a corner of the building for ORT and observe when he was given ORS by his mother. The distance away from others wasn't good enough especially if the definite diagnosis was cholera which was one of the differential diagnosis due to rice-water colour of his stools. Thinking about cholera in his case was an act of being on high alert on our part as we are in rainy season and some parts of the country including Nkhotakota are receiving heavy rains.

The outbreak of Cholera is one of the outbreaks that are catastrophic. This burden is disproportionately borne by the young, with under five having the highest incidence of cholera and contributing almost half of the mortality (2) More than 60 years ago a study was conducted in Pakistan and reported that the cholera case fatality rate among children one to five years old was more than 10 times higher that of adults (3). There seems to be no recent study to back these findings. Another study shows that increased age, lower socioeconomic status and lack of breastfeeding are key correlates of increased risk for cholera hospitalization among under five children in rural and urban Bangladesh (4).

On the good note, we are not the only ones who are attentive as far as cholera is concerned. The issue of the Nation newspaper for 07th January, 2020 said some public hospitals are on cholera alert. As part preparations, some District Hospitals including Nkhotakota have, among other things, increased awareness of the diseases, have in stock cholera supplies and sensitizing the communities on how to provide first aid to a suspected patient (5).

RECOMMENDATIONS

1. We need to include precautions for cholera in volunteer training
2. Take part in sensitizing the communities about cholera and its preventive measures as we know that the sites we go with our clinics are rarely reached by the government
3. Have supplies in place in this rainy season.

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The Mobile Clinic: we uncover a horrendous and secret practice.

It appeared to be just another mobile clinic with all the usual cases, with as ever some seriously ill children requiring referral. Benjamin, our new Clinical Officer called me over to see a 3 year-old boy; the child had bleaching of the skin on his hands and lower arms.

The child had been brought to the clinic by his aunt, because we discovered, the mother did not dare show her face. The reason? The mother was the cause of the injuries, she had tortured the child by holding his hands in boiling water. His crime? He reached for more porridge…

The child first appeared at our clinic with his burns five months ago, again brought in by his aunt. Our Chief Clinical Officer told her "When you see the mother, tell her when this boy is 15 I will fund him to sue his mother for this appalling cruelty!".

We presumed this was a one-off, isolated incident but took the matter up with the group village headman who was at the clinic. He admitted that extreme cruelty to children was common in the villages. This was confirmed by the headline on page 3 of The Malawi Nation newspaper the very next day. "Mother imprisoned for burning her son with a red-hot knife for eating beans meant for Christmas".

The deeper we dug, the more evidence of child cruelty and abuse we uncovered, as well as child defilement, child prostitution and forced labour. The problem we discovered is that in the cities there are child support units in the major hospitals, that are linked to social workers and the police. There are courts and magistrates to deal with offenders – but in the villages far from the tarmac road where we work, there is absolutely nothing in place.

Our mission is to care for vulnerable children and we cannot turn a blind eye to what we have uncovered and the battle against child cruelty will become partr of our Mobile Clinic programme.

We met up with people with experience and expertise in this field and collaborated on drafting a project.

It can be summed up as SEE (Sensitise, Educate, Enforce).

1. Sensitise the traditional Authorities (the village and group headmen/women, the senior chiefs) and gain their vital support.
2. Public education with meetings in the villages and radio broadcasts.
3. Enforcement through local representative (i.e. Point of contact) in every village, supported by a tribunal to hear cases of cruelty and abuse with the powers to call in the police or social workers when necessary to deal with offenders.

To that end we have met with the Minister and Permanent Secretary responsible for Gender and Children and they have pledged a letter of support for our planned project.

This is a urgently needed project and it is a battle we can win - and if we save one child from the torture suffered by the child we met it will all be worthwhile.

MB

A hard row to hoe for Prisca

Background Information

At our mobile clinic we meet children who present having been infected with the Human immunodeficiency virus; as a facet of our mobile clinic we are providing long-term care for these children.

Prisca is a girl of eleven years who was born in Chunga village Traditional Authority Malengachazi in Nkhotakota District in Malawi. She was born in a family of five children, her being fourth born and was raised by a single parent, her mother. The mother was HIV positive and Prisca was also diagnosed HIV positive in the year 2011 when she was 1 year 11 months. She was initiated on Anti-retroviral Therapy (ART) in the same year she was tested for HIV. She qualified to start ART because she was in WHO clinical stage 3 as the criterion used that time.

Down of Challenging Situation

Prisca's mother died when the girl was 1-year 7 months old. Her elder sister died of malnutrition a month later after the mother's death. Her Uncle took over the responsibility of caring for her. The Uncle practiced polygamy and had two wives and many children. She was kept at the house of the second wife of her Uncle. Prisca admits that care wasn't enough for her in that new house. Despite this situation, her Uncle tried his best to give attention to her in times of her illnesses. For instance, when she had a cough and became breathless in January of 2011 her Uncle took her to the nearest health facility where she was diagnosed to have severe bacterial pneumonia. Her clinical presentation prompted the clinician to test her for HIV which came out positive. She was initiated on Anti-retroviral Therapy on 27th January 2011.

Attempts to Make Her Life Better

Her condition improved tremendously since she started ART and her Uncle was very supportive in terms of keeping appointment dates and giving the medications daily to the girl. During those initial days on ART she had good physical health.

Later things changed for bad to her. Her lovely Uncle died, and she had to move to the house of her Aunt. Her Aunt managed to get her to our clinic for ART, though irregularly until September 2019. Since then she was lost to follow up. Confirmation of her being a defaulter was made on 06th December 2019.

Her Own Attempts to Make Her Life Better

Prisca reappeared at our clinic on 23rd January 2020. She admitted that it was her initiative to come back to the clinic after three months. She told us her Aunt is not assisting her now as far as ART is concerned. She doesn't care for her now. To come back to the clinic on this day she had to ask her cousin, a boy to escort her. They hired a bicycle taxi cyclist to bring them to the clinic, a distance of 22 kilometers. This time she doesn't look the way we thought she would

when she was doing better on ART years ago. She was losing weight and had skin lesions which we think they indicate decrease of her immunity.

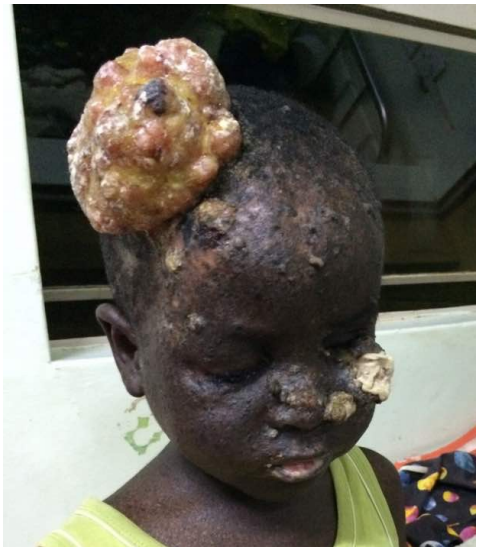
Recommendations

Prisca is just one of many young ones who are struggling to find basic things that others just take for granted. She doesn't have the family to support her in times of need.

Now she is growing and has come to understand the importance of ART. We can do our part by supplementing what she can't do on her own. She needs friends to support and encourage her on taking medications she is on. She needs financial support to cover transport expenses to and from Thandizo clinic. They can become like close friends and supporting friends to her. Well-wishers who can assist her on transport issues will be highly appreciated.

Benjamin A; Paediatric Clinician.

CHILDREN WITH CANCER

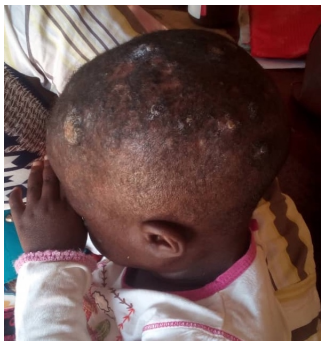


This young boy finally presented at our children's mobile clinic. Blind in one eye with squamous cell carcinomas, we diagnosed Xeroderma Pigmentosum, a genetic disorder in which there is a decreased ability to repair DNA damage such as that caused by ultraviolet (UV) light.

He must have been suffering for several years and we feared it was far too late but did everything in our power to save him.

We referred him to the child oncology unit in Lilongwe that is funded from the USA and delivers high quality care and carries good stocks of chemotherapy medicines.

Initially things looked promising with some signs of success but he he sadly lost his battle.



In October the boy's mother brought her three year-old daughter with obvious signs of the same condition but at an early stage.

There is no cure for this condition but there is at least something we can do. The sun causes the problem so protection is vital.

We have bought need 100% UV blocking sunglasses, hats that give protection (see below), long sleeves and factor 50 sun cream.

<u>UPDATE JUNE 2020.</u>

We have sadly lost this battle; the cancer has spread at an alarming rate and all that is left is palliative care.

There was a shortage of morphine but with the determined efforts of one of the final year medical students spending their elective placements with us we managed to find a source of supply

It is very sad; we hate to lose and we win many battles – but sometimes the odds are just stacked too high against us.

We will never stop trying…

CHALLENGES WE FACE:

2019 AND THE CYCLONE:

Disaster struck when we caught the tail end of the Idai cyclone that devastated the region. Our premises were severely damaged, the only good news was that the medical students with us at the time were unscathed. We launched an appeal, dug into our precious reserves and the repairs that lasted for 6 months finally finished in October.

March 2019

October 2019

Our sincere thanks to Fondation Eagle for their ongoing support.