

THE Health Digest

Issue 08 | December 2016

SAVING THE MOTHER AND THE NEWBORN

FOOD
The first
1000 days

BABIES
The three
common killers

REFERRAL
Back to
the basics



HEALTH
Journalists
NETWORK IN UGANDA

Empowering public health workers to improve health outcomes



Save the Children

Inside this issue

1.	Table of contents	Page 1
2.	Message from the editor	Page 2
3.	Letter from Save the Children	Page 3
4.	What does the mirror say?	Page 4
5.	The three common baby killers	Page 15
6.	Good feeding generates good baby health	Page 18
7.	We need a stronger referral system	Page 21
8.	Saving Uganda's mothers and newborns	Page 24
9.	Customer care at hospitals	Page 26
10.	Hard to reach: Busanza in Kisoro	Page 29
11.	Remoteness problem in Hoima	Page 32
12.	Gains for mothers and newborns	Page 34
13.	Counting the dead: Will it be helpful?	Page 36
14.	Why mothers still vote for TBAs	Page 38
15.	Good policies but dismal performance	Page 40
16.	Reducing deaths by 2030	Page 43

To buy this copy at
SHS 7,000 or US\$ 3,

Call: 0704 292188
0712 685837
0703 826623

Our advertising rates are as below (inclusive of 18% VAT);

Size	
Full page	3,600,000
Half page	1,800,000
Quarter page	900,000

For advertising, contact Bagenda Elliot on 256 712 685837



Editorial Team

Managing Editor
Esther Nakkazi

Editor:
Hilary Bainomugisha

Senior Consulting Editor:
Christopher Conte

Contributing Writers:
HEJNU Team
Guest writers

Design/Layout
Bagmuz Creations

Send all correspondence to:
Plot 156-158
Mutesa II Road, Ntinda
P. O. Box 4883
Kampala -UGANDA
Tel: 256 704 292188
healthdigestUG@gmail.com
Website: www.hejnu.ug

Editor's Message

**We know what should be done;
let us do it and do it right**

Child birth is usually a major event in every family in Uganda. The anticipation and excitement! The implication of worth in society! The expectation of a new member! All these build up with every one of the nine months.

So, when the baby or the mother dies, it becomes a big plunge from expected celebration to hurtful mourning and a haunting pain.

Yet it is within the means of modern society to ensure safety for mothers and their newborns. But our health system, social support, Government priorities, and individual beliefs and choices still keep pregnancy looking like a battlefield from where the mother may not return.

The Health Digest reveals how most deaths are preventable, how investment in maternal and newborn health needs to be improved and how solutions need to come from multi-disciplinary and inter-agency strategies. For example, while Health needs to improve services, Education needs to give us properly trained health providers and keep girls longer in schools while Agriculture needs to facilitate better nutrition and food security. Works need to ensure accessibility of health facilities, Energy for electrification especially of rural areas and Gender for social mobilisation and sensitivity while Finance needs to ensure adequate budgets for Health.

Most of the situation *The Health Digest* covered show that most maternal and newborn deaths can be prevented at four levels of intervention; individual, community, institutional and Governmental provision and supervision.

Our findings suggest that, although we are not there yet, we are in the right direction. It is as much a Government duty as it is an institution, a social and an individual role to make it better. Any false step by any of the stakeholders frustrates the entire system. We know what is right, we should do it.

We thank our funders and developmental partners, especially Save the Children, for their efforts in ensuring that each mother comes out alive and with a healthy baby.

Executive Summary

Every day, 16 women die in Uganda from pregnancy and childbirth-related causes, 94 babies are stillborn and 81 newborn babies die. This equates to 69,570 deaths each year due to complications during pregnancy, childbirth and in the first month.

Many of these deaths are from causes that are largely preventable, with maternal deaths caused by four major factors – haemorrhage/bleeding, hypertension, unsafe abortions and sepsis. Babies die mainly due to complications of prematurity, complications at birth and neonatal infections.

It is a fact that access to a trained health care worker, along with basic medicines such as antiseptics and antibiotics, vital equipment and a clean environment to work in, can save the lives of nearly-born and newborn babies. However, only 57% of births in Uganda occur with the support of a skilled health care worker and many health facilities are under-equipped and under-staffed.

To stop women and babies dying unnecessarily during labour, birth and the first day and week of life, key changes in the delivery of basic healthcare are urgently needed. The Government of Uganda has committed to ending preventable maternal and newborn deaths by 2030 as part of the Sustainable Development Goals and the Every Newborn Action Plan. National policies and strategies are in place, such as the National Roadmap for Maternal and Newborn Survival.

The voices for Uganda's newborn babies and their own rights needs to be amplified by parents, communities and health workers in order to hold Government, donors and others accountable to these commitments.

Save the Children has worked with the Health Journalists Network of Uganda to compile articles on newborn and maternal health, which, we hope, will expose the various challenges that communities (especially women) face in seeking health care, as well as the efforts in place to mitigate them.

Who can better appraise maternal and child health services in Uganda than the direct users? A team of journalists visited selected centres in Isingiro, Kiboga, Mukono, Buduuda, Adigo, Mbarara and Sembabule. They talked to users and providers of health services about what needs to be done to make it better.



Mothers at an immunization centre in Mbale

What does the mirror say?

Teenage pregnancies dog Isingiro

By Esther Nakkazi

In many rural areas, maternal and child health service outcomes are determined by an interplay of issues like inadequate resources, lack of skilled health workers, cultural beliefs, congested health facilities and teenage pregnancies.

A case in point here is Rwekubo Health Centre IV, which I visited and found a 17 year old girl, Rosemary Kukiriza, three hours out of theatre, occupied with grief at the loss of her first born baby.

Located in western Uganda, on the Uganda-Tanzania border, Isingiro has about half a million people with no referral hospital. Rwekubo health centre IV is one of the two biggest and busiest health providers.

Kukiriza's 36 year old mother was exhibiting her grief and anger by talking loudly about her dissatisfaction with the services at Rwekubo. This would have been her first grandchild.

"My daughter is old enough to give birth," she said, "I was 14 when I produced her!"

Both Kukiriza and her mother have been teen mothers, which according to the World Health Organisation (WHO) is dangerous for both mother and baby as stillbirths and death in the first week of life are 50 percent higher among babies born to mothers younger than 20 years than among babies born to mothers 20-29 years old.

Deaths during the first month of life are 50-100 percent more frequent if the mother is an adolescent versus older, and the younger the mother, the higher the risk, says the WHO, also the rates of preterm birth, low birth weight and asphyxia are higher among the children of adolescents.

In Uganda, 140 per 1,000 teenage girls get pregnant annually compared to 41, 101 and 128 in Rwanda, Kenya

and Tanzania respectively according to UNFPA.

Kukiriza's mother complained about the delays after they got to Rwekubo health centre saying they arrived in the night but her daughter was only taken to theatre at 10am in the morning, six hours later!

But according to the in-charge, Dr Gamukama Tuhaise, specific theatre procedures have to be followed before a patient is taken for a caesarean section; blood type established, vitals taken, theatre cleaned and prepared, fuel for the generator bought and the lone anaesthetist called in.

The health centre IV has one oxygen point, no running water, a few health workers and no electricity. Once a week a truck delivers water for use. The generator sometimes jams. And the only anaesthetist has to be called on demand because he cannot stay on standby when he is needed elsewhere.

He said preparation of the theatre takes about 40 minutes and although Kukiriza's baby was alive at delivery, it died a few hours later from exhaustion.

"Efforts to resuscitate it did not yield much partly because these women take herbs they believe will enhance smooth delivery. The herbs instead thicken the fluids, which get logged in the baby, making it difficult to resuscitate it," said Gamukama.

Asked which particular herb was responsible the doctor said he did not know but advised women to stop taking herbs when pregnant.

He explained that due to limited resources and manpower doctors chose between saving the mother and the baby.

"If you resuscitate a baby for an hour and there is no response you take a decision and turn off the oxygen. If only there was another doctor-led team in the theatre to handle the baby it would be easier but I have to handle both mother and baby concurrently," said Gamukama.

"Usually, the preference is to save the mother."

Looking at the health centre IV month's records, of the 70 maternal related operations, most of them handled by Gamukama who is just two years in medical practice, 20 percent are of teenage mothers aged 16-19 years and their babies often die.

Almost a baby dies everyday at Rwekubo health centre



TEEN PREGNANCIES: A 13 year old who gave birth in Nebbi IV. The teen mothers seem unperturbed and try again quickly.

"It does not affect them much," said Gamukama. "One year later, they will be back here. They are usually pregnant within the next three months after losing a baby." But why?

"Maybe it is a psychological urge to fill the void immediately, or stop the scorn and stigma by village communities who are likely to talk about 'the daughter of so and so who has failed to bear a child for our son.' But there is also prestige in switching names to 'mama boy' or whatever name the first born child bears and merely just to prove themselves," a nurse explained.

At the health centre IV, another 17-year-old girl, Ainemabazi Brenda was camped there for the last one month. In her third trimester of the pregnancy, she had no complications yet, but, being a teen, she was advised to stay.

"When the teen mothers stay here, it reduces the risk of losing the baby and it keeps us health workers updated on every step," said Gamukama.

However, its expensive for the families that have to ferry daily meals and for the health centre which has limited space. But, according to Gamukama, it is worth it.

"If Kukiriza had come in at least 24 hours before the onset of her labour, her baby would be alive. To stop babies from dying, we need to solve the problem of poverty as well," he said.

Lack of facilities in Kiboga

By Nelson Kiva

Baby cries, screams of delivering mothers and loud instructions from two busy midwives on duty are the welcome signs to Kiboga Hospital labour ward. It is scary and paints an imagery of women facing death. Yes, that is what pregnancy has come to be. Uganda is one of the ten countries with the highest maternal and newborn mortality rates in the world. World Health Organisation (WHO) says in 2013, 5,900 women died during pregnancy or childbirth and 35,000 babies died in the first month of life in Uganda.

At Kiboga Hospital, the midwife, only known as Musawo Mable, says on average, 16 babies are born daily. Referring to June as an example, Mable says the ward received 62 teenagers mothers (15-19 years) and 12 of these delivered by caesarean. 98 were 20-24 years old and 79 of these had normal deliveries. 101 were above 25 and 13 of them were delivered by caesarean section. They lost about 20 babies.

Resty Nakasaga, 16, is among the girls who lost their babies. Her 3.6Kg baby boy passed away after only an hour. Flavia Magulu, a midwife who attended to her, said the baby suffocated when an umbilical cord got wrapped around its neck during delivery. Dr. John Zzimula, an intern at the hospital, says if they had oxygen at the hospital, they would have saved the baby. But they do not.

On the next bed, Solomy Nabuule, 32, from Butemba sub-county in Kyankwanzi district is breast feeding her baby boy. Her husband Azza Richard is by her side. Azza brought Nabuule to the hospital at 6pm on a Tuesday and 11 hours later she gave birth.

Ciyema Nabirinda, 21, arrived on Tuesday too and eventually had a caesarean section on Thursday. It was her first born, a baby girl. She was grateful to the medics who helped her in time.

Zzimula noted that the success of mothers delivering depends on timely decisions right from the days of antenatal to the timely arrival at the health facility. Many children and mothers who die come late when it is too late to effect a successful intervention.

The Kiboga district health officer, Dr. Michael Musiitwa, said they were working with NGOs like Save the Children to sensitize mothers on the importance of timely decisions through antenatal meetings, community outreaches, radio programmes and spot massages.

Kiboga hospital serves Kiboga, Kyankwanzi, Mubende, Mityana and Kibaale districts.

The biggest problem in the area is that many women

still do not deliver in health facilities. Musiitwa said that in Kyankwanzi district, out of those who attend the first antenatal clinic, 45 percent drop out by the fourth antenatal visit. And when it comes to delivery time, only 29 percent of mothers return to health centres.

Musiitwa cited reasons such as cultural, financial, misconception, accessibility, belief in traditional birth attendants, some of which are beyond the health department. For instance, in a meeting held recently at Kiyuni Health Centre III, residents cited poor roads among the reasons that hindered access to skilled care during delivery. Scola Nakate a pregnant mother from Mulagi Sub-County in Kyankwanzi, cited unfriendly midwives and referred to Nnalinya Health Center III as an example as with lack of privacy.

The Kyankwanzi district health officer, John Bosco Sserebe said lack of facilities is because the district had no capacity due to limited funding.

“For instance we get Ush1.2m in three months to administer a Health Centre III. But to have an efficient functional maternity ward requires about Ush80m a month. So Health Centre IIIs such as Nalinya, Sirimula, Kiyuni, Butemba have no maternity wards,” he said.

Kyankwanzi lacks a hospital and mothers have to move to as far as Hoima or Kiboga. The LC5 chairman, Leopold Ddamulira Kinene, said that for over four years, they have lobbied the government to upgrade the only Health Centre IV at Ntwetwe to a district hospital in vain.



KIBOGA TRYING HARD: Health officer said NGOs are helping the hospital's maternal health services



KEEPING AHEAD: Mukono has completed a new building at the health centre

Mukono, an example of success

By Emmanuel Ainebyoona

According to 2015/16 Annual Health Sector Performance report, Mukono Health Centre IV ranked as a model health facility in Uganda. The report says the health facility lost only six lives (both mothers and babies) since 2004, with an average of 18-20 deliveries daily, including at least two caesarean births.

The Principal Medical Officer for Mukono Municipality, Dr Anthony Kkonde says only two deaths out of 6,322 deliveries were registered in the 2015/2016 Financial Year. 1,013 were caesarean.

He attributes this success to interventions the health facility has put in place, like emergency obstetric and neonatal intensive care services. He also hailed partnerships with other entities like Uganda Christian University, Mukono and the Save the Mothers Programmes. Through them, Mukono has received interns from within and outside the country.

“We have also created a dedicated team and prioritized maternal health,” he says, “Our health workers are continuously sent for training to gain more skills.”

However, he says, there are still challenges in how to address emergency situations at birth. Mukono's biggest emergency is bleeding before and after birth. Some mothers get to the health facility after unsuccessful abortions and others bleed due to ruptured uteruses.

Kkonde says emergency care is crucial in ensuring child and maternal survival but access to it remains low in Uganda due to lack of equipment, infrastructure and skilled staff, among other reasons.

Mukono's success is because of its capacity to offer emergency care and caesarean section.

Associate Professor, Department of Health Policy, Planning and Management, Makerere University School of Public Health, Prof. Peter Waiswa said in a presentation that if all mothers and babies had access to emergency care, many lives could be saved.

Waiswa gave an example of babies with birth asphyxia dying because half of the facilities do not have simple equipment like resuscitation devices or drugs or health workers with skills to carry out a resuscitation procedure which is an emergency. Caesarean services are a must have but most rural health facilities do not have them.

Kkonde explains that mothers often go to health facilities in emergencies like obstructed labour, cord prolapse, ruptured uterus, pre-eclampsia and some arrive late after other interventions have failed. If a health centre is not equipped to handle such emergencies, many deaths occur.

Pre-eclampsia is pregnancy-related high blood pressure. The mother usually develops severe fits, which

can cause death of both the mother and unborn child. It is a leading cause of newborn deaths and premature babies in Uganda.

This remains a big challenge because most women especially in rural areas prefer to be attended to by senior family members or traditional birth attendants and only

report to the facility when life threatening complications arise.

Kkonde advises mothers to attend all their antenatal visits in order to avoid these emergency situations. He also says that mothers should avoid taking herbs when they are pregnant.



IN THE MOUNTAIN: Buduuda covers areas in rural mount Elgon sub region

Hospitals are a last resort in Buduuda

By David Mafabi

Justine Nabifo, 24, of Bushiyi Sub-County in Nusu village in Bududa district, had two successful home deliveries. So, her husband, Peter Wamanyanya, 37, expected her third pregnancy to be the same.

So, when the labour pains started, he urged her to push. But this time, something went wrong. Nabifo kept on bleeding profusely and was exhausted. Wamanyanya rushed to inform relatives, who fetched the village stretcher (*ingoozi*: a blanket tied to two poles at each end) and rushed her to Bududa district referral hospital.

She did get to the hospital but lost her baby. Doctors said it was exhausted.

Adjacent her bed in the same maternity ward is 32 year old Mary Nakhumitsa from Nametsi, about 18 Km away from the hospital. Her baby also passed on. Her

mother, Margret Makuma, who was attending to her, said they encouraged her to push until they realized that she could not, and rushed her to hospital.

In the same ward, Caroline Watsemwa from Bufukhula, Bukigai sub-county, arrived at the hospital in time and two hours in the theatre enabled her baby boy to survive. Her neighbours say she was lucky she stays 3km from the hospital.

Many are not that lucky. Jane Nakwekwe, who lives in Mabono, Munyende village, an isolated community in the mountains, says it would take her seven or eight hours to get to Bududa hospital.

“After all my husband and I can’t afford the costs of transport and hospital. So, I have given birth to seven children here in my home. Four died within a week be-

cause of lack of treatment but we just don’t have money. We just make enough to feed us.”

Agatha Nafuna, a midwife at Buduuda says most women deliver at home and try traditional birth attendants when there is a problem. It is only when they get complications that they rush to hospital and, usually it is too late.

Dr Imelda Tumuhirwa, the medical superintendent, Bududa hospital, says on average a new born baby dies daily because mothers arrive late. She says with limited resources and workforce they cannot handle many emergencies at one go.

Mothers come too late at Sembabule

By Malik Fahad Jjingo

Monica Ssembusi, of Sembabule Town Council is a mother of two. She has just delivered her second child at Sembabule Health Centre IV.

“I started visiting the health centre as soon as I realized I was pregnant,” she said. “I attended all the antenatal care and even came for check up every time I felt uncomfortable. When contractions came, my husband, Joseph Ssembusi, took me to Sembabule.”

Sharon Ampeire of Kikoma Village, Mijwala Sub County, in Sembabule District, says she would have lost her life or baby if she delayed at home or on the way. She got an unexpected obstructed labour and was advised to go for a Caesarean section for her third baby who doctors said was too big.

However, Mable Kyomuhendo, of Mbale village, Lwebitakuli Sub County in Sembabule district lost her baby because she arrived late at the health centre. She first tried her luck at a traditional birth attendant (TBA) but was referred.

Joeria Nakamya of Kyabi village in Lugusulu Sub County, also lost her baby in spite of the cesarean section. Dr Maria Nanteza, who operated on her, observed that she didn’t get antenatal care, and that suggests any number of problems may have gone undetected.

The District Health Officer Bulambuli, Dr. Muhammad Mulongo said while prolonged labour, pre-eclampsia and infection are registered as the biggest causes of baby deaths in Bulambuli, the fundamental problem is inaccessibility and unavailable quality care.

“I know over 63% of the people in rural Mt Elgon sub-region give birth at home under TBAs because health facilities are far and some don’t have medical workers.” Different from other parts of the country the eastern region has high malnutrition which also affects baby birth outcomes.

Sembabule District Health officer, Dr Charles Matovu, says their Health Centre delivers about 40 babies every week on average. He advised mothers to always seek medical services from qualified health workers, which are available at the health centre instead of going to TBAs and private health units, most of them operated by quacks.

Many women arrive after losing a lot of blood.

“We are carrying out sensitization campaigns in communities on the advantages of seeking antenatal services on time and are giving mosquito nets as incentives to mothers.”

*Dr Charles Matovu
Sembabule District Health officer,*

“It is hard to save either a mother’s or a baby’s life after over bleeding. At times we run out of blood and have to refer patients to either Villa Maria Hospital in Kalungu or Masaka Regional Referral Hospital. Those are far off and in the process we may end up losing them,” he said.

He adds that many women, especially in rural areas, are reluctant to use family planning services even when they are free in public health units in the district. That causes high rates of unwanted pregnancies.

In most of the rural areas of Lwengo, Lyantonde and Bukomansimbi mothers tend to use TBAs, citing lack of patient care from skilled health attendants.

Matovu says they are carrying out sensitization cam-



LONG HOURS: Patients waiting for attention at Sembabule HCIV

paigms in communities on the advantages of seeking antenatal services on time and are giving mosquito nets as incentives to mothers.

They are also engaging local and religious leaders in mobilizing people to always seek medical services from qualified health workers instead of turning to TBAs.

Matovu said whenever they meet health workers, they encourage them to treat mothers with respect and en-

courage men to accompany their spouses for antenatal services.

Those who are escorted by their husbands are served first to encourage women to bring their husbands along. This has improved retention. About 8 out of 10 mothers who attend antenatal care, deliver at the health unit.

Adigo women complain of extortion

By William Moi

At Adigo Health Centre II, Namata Eunice, 27, a new mother of a baby boy, complained of extortion, saying that nurses and midwives demand money from them saying it is needed for buying soap and jik to clean the blood on the floor.

“Thereafter, they still expect a token after safe delivery of a baby,” she added.

The demand for money was confirmed by Sarah Owiny Dennis, a teacher of Prima Nursery School, who also delivered at the health centre.

“I don’t know if it is official payment. But, if it is not, they should stop it immediately. They also don’t give

us mama kits which we are told are free elsewhere but instead they ask us to buy them from privately owned clinics nearby,” said Owiny.

Awio Tonny, a father of twins and a peasant of the same location, suggested that complaints against nurses and doctors who receive bribes should be addressed seriously by higher authorities because he believed they were aware.

Namata, a food vendor and single mother of Akica Cell, Adigo parish, Loro Sub County in Oyam district, also says complained of congestion in the maternity ward.



THEY ABUSE US: Namata at Adigo health centre

“Mothers share beds, mattresses and bed sheets. We share latrines with men. There is no privacy at all. This overcrowding must be the cause of infectious diseases. The latrine and bathroom are dirty,” she says. “At least they should employ one casual worker to help in daily cleaning and management.”

The expansion of the maternity ward and labour room actually started but didn’t go beyond half-finished walls.

Namata also complains of harassment by some nurses.

“They use bad language like: “Am I your husband? Stop making noise for us!” Yet when one is in labour pains, you need mercy and understanding,” Namata said.

Another mother at the health centre, Tina Abal, said Adigo has no doctor which makes it hard for health workers to handle complicated cases especially for young mothers. There is no ambulance to take patients to another facility when referred.

Mbarara, a referral crying for better facilities

By Annita Matsika

In Mbarara, Rachel Nimusiima, 23, lost her third baby because she was brought to Mbarara Regional Referral Hospital late. According to the doctors, the baby was born tired.

It was not her fault. She actually went to Kariro Health Centre III, Lyantonde District, where she expected to deliver from in time. But due to complications, she was referred to Lyantonde hospital, 20km away.

There are no ambulances so she hired a vehicle. At Lyantonde, she spent about 10 hours before they realized it was complicated and again referred her to Mbarara Regional Referral Hospital, 67 km away. Still there was no ambulance.

She arrived on 3rd August, 15 hours from the time she presented herself at Kariro and wishes she had gone

straight to Mbarara instead of wasting time.

Dr Elly Agaba, a senior Gynecologist at Mbarara Regional Referral Hospital, says that at least 180 - 200 mothers deliver every week at the hospital. 50 - 70 of these are by caesarean section.

“Even when caesarean is lifesaving, it still carries a risk of death, complications or bad outcomes. “Yet it could be avoided by always attending antenatal services and proper planning and arriving at the hospital in time,” Agaba said.

He wants the government to set a system that is fully equipped and ready with the man power to work on emergencies.

“We need a steady supply of medicines, theatre equip-



INITIATIVE: A new block at the Mbarara Regional Referral Hospital

ment, ambulances, health workers and drugs,” he said. It is so demoralizing to lose a mother during delivery, he said.

Cissy Nantumbwe, 32, of Busega, Kibumbiro recalls so clearly the cold Wednesday morning on the 7th day of October, 2011 when she lost her first child at birth. She had visited an antenatal clinic throughout her entire pregnancy at a nursing home in Busega where she was assured that it was a normal progressive pregnancy with no risks at all.

But, on the last day, the cervix failed to open wide enough. Nantumbwe needed an emergency caesarean section. The baby died. She is not sure what exactly happened.

Nantumbwe provides a bad example for many rural women to use when justifying their decision to go to traditional birth attendants. They argue that mothers also die in hospitals. They trust the TBAs even if they lack knowledge and training and use traditional practices that have led to risky medical procedures resulting in high maternal mortalities.

However, not all hope is lost as the health ministry officials in Uganda say measures have been under taken and are still being undertaken to curb it down.

Dr Katumba Experito a gynaecologist, notes that they have managed to sensitize mothers through mass media to visit qualified health workers in well-equipped health facilities because the safety of the baby and mother entirely depends on the two.

“A woman should be examined thoroughly through anti natal check-ups for early assessment of any conditions that might lead to deaths of both the mother and baby.”

Dr. Katumba also notes that with the introduction of Option B plus in April 2012, all HIV positive pregnant mothers should immediately start on ARVs no matter the CD4 count to stop transmission of HIV from mother to child.



SQUEEZED: A mother in the maternity ward in Mbarara



EXTERNAL ASSISTANCE: Volunteers at Hoima Hospital

Hoima women face challenges at delivery

By Francis Mugerwa

Herbet Munyomo, 40, of Kigorobyia Town Council in Hoima District was excited when his wife Catherine Aheebwa, 22, conceived. He accompanied her to all antenatal visits at Kigorobyia Health Centre IV and was assured everything was right. And when his wife developed labour pains, he rushed her to the health centre in time.

“On Sunday, I was told her case was complicated and required an operation which the health centre could not do. We were referred to Hoima Regional Referral Hospital, about 15km away,” Munyomo said. “We hired a car at sh200,000 to Hoima and arrived at about 10am on Sunday. We did not get any attention until around 3pm on Monday. But it was too late. Our baby was de-

livered at 4pm, already dead.”

Each day in Uganda, more than 94 babies are still born. Half of these die during labour and childbirth complications which should be prevented with quality care at birth.

Munyomo believes it was a case of negligence by health officials at both Kigorobyia and Hoima and, so, wants to sue for negligence. His friends are discouraging him saying medical officials may shun him later when he seeks services at the facilities, but he is determined.

The incharge of Kigorobyia Health Centre, Mr David Andia said health workers at the facility give their best

and ruled out negligence. He said between 150 to 200 mothers come for antenatal care every month and 70-150 deliver at the facility every month.

“Out of these, about 15 are referred to Hoima Regional Referral Hospital for cesarean operations. Our theatre was constructed in 2010 but it is still not operational” Andia said.

Another mother, Beatrice Ngonzi, of Iseisa village, Kitoba Sub County in Hoima district delivered normally on August 17th at 11pm at Karongo Health Centre in Hoima municipality. The 30-year old mother of seven said she missed one antenatal appointment because of long distance. She had to travel 9km from her home. And a bodaboda cyclist charged sh10,000 to and fro which her husband did not have. That was the reason he did not accompany her to the health facility.

“The health worker was friendly and I didn’t experience any challenges. I was offered free Mama Kit which contained a bar of soap, a black polythene bag and baby cards,” she said. “But after delivery I was told to buy panadol and flagyl from private clinics because it was out of stock at the hospital. I also did not buy because I didn’t have money.”

The Hoima Hospital Medical Director, Dr Francis Mulwany, said maternal and newborn deaths were high because mothers arrive late at the hospital.

“Out of the 6,290 deliveries that were registered at the hospital in 2014, we lost 37 mothers and 251 were still births.”

Dr Tom Ediam, the head of the pediatric department at the hospital said 28% of the 119 babies admitted annually at the hospital are premature. Some are admitted suffering from brain injuries due to prolonged labour while others suffer from infections.

Between January and June this year, 4,447 mothers attended antenatal visits and of these, 3,226 delivered at health facilities in the region. Teddy Behemirwa, from Kamusunsi village, Bulimya parish in Kiziranfumbi Sub County said she delivered two of her six children without attention from any trained health worker because

some health workers mistreating mothers.

“I have seen midwives abusing mothers who turn up without clothes for babies, soap, gloves and other necessities. They need to appreciate that some of us come from poor homes that cannot afford all the necessities required at delivery,” she said.

Florence Nsungwa, of Rwamutonga village, Katanga Parish, Bugambe Sub County in Hoima district said she has delivered all her seven children with the help of traditional birth attendants because the nearest health centre to her home, Buseruka Health Centre III is 8km away.

“One time, I attempted walking and collapsed along the way,” she said. “Health workers should conduct mobile antenatal outreaches in communities to give services to vulnerable community members.”

Judith Kiiza, a midwife who has spent two years at Karongo Health Centre said while the number of mothers seeking antenatal services has increased, they deliver few.

“We deliver 15 mothers every month out of over 160 who come for antenatal. Retaining them up to delivery is a problem. But still, there is an improvement. We used to receive only about 5 mothers for deliveries two years back.”

She attributed the increase to increased sensitization and availability of Village Health Teams (VHTs) who help to refer them to health facilities. She also says they used to ask mothers to come with torches or candles but now electricity, which was installed at beginning of this year, has excited mothers. Medical officials also halted giving Mama kits to mothers at antenatal visits and now give at delivery.

The Hoima District health inspector Mr Fredrick Byenume said whereas every health centre IV is supposed to have a functional theatre, Kigorobya, Kyangwali and Kikuube don’t have. They lack adequate equipment, anesthetic officers and ambulatory services.

According to Byenume, the district has sought intervention of the Ministry of health and is still waiting.

“We deliver 15 mothers every month out of over 160 who come for antenatal. Retaining them up to delivery is a problem. But still, there is an improvement. We used to receive only about 5 mothers for deliveries two years back.”

*M/s. Judith Kiiza,
A midwife at Karongo Health Centre*



The three common baby killers

By Violet Nabatanzi and Ruth Nazziwa

Dr Nicolette Nabukeera, a paediatrician at Shalom Doctor’s Clinic, explains that newborns are more susceptible to certain diseases because their new immune system is not adequately developed to fight the bacteria, viruses, and parasites that cause infections. Many infections are transmitted from mother either during pregnancy, delivery or parenting. Others are got from the delivery environment.

According to the 2014 WHO figures on Uganda, about 20 women out of 1,000 were losing their babies within the first seven days of life in 2011.

About 35 percent were dying within the first 24 hours, 20 percent on the next day and 11 percent on the third. By day 4, chances of survival were higher (only 8 percent die) and kept rising with every passing day (1 percent on day 5, 0 percent on day 6 and 1 percent on day 7).

UNICEF data of 2015 shows the three major causes of deaths for babies under one month in Uganda to be premature births (28 percent), suffocation (birth asphyxia) 27 percent, and bacterial infections (Sepsis) 18 percent.

Premature births

Dr Margarete Nakakeeto, a consultant neonatologist at Kampala Children’s Hospital, says anybody born before the start of the 37 week of pregnancy is considered a premature birth. Normally, a pregnancy usually lasts about 40 weeks.

Doctors say that although many of these babies can survive with intensive care, such care is not available in many health centres, especially in the rural areas. According to Nakakeeto, the main causes of prematurity are malaria, hypertension, multiple pregnancies (twins), diabetes and being either obese or underweight. Others are vaginal infections, tobacco smoking, and psychological stress.

Children who survive often face lifelong disabilities, including learning, visual and hearing problems and their quality of life is greatly affected.

The doctor says nearly 85 percent of preterm babies are born between 32 and 37 weeks gestation and most of these babies do not need intensive care to survive unless they are born with low birth weight. But those born earlier need essential newborn care which includes

drying, warming, immediate and exclusive breastfeeding, hygiene and cord care. They also need continuous skin to skin contact, antibiotics, and antenatal corticosteroids.

“More effort is needed to identify women at risk of pre-term labour and support them in a health facility that can offer extra care when needed,” Nakakeeto said.

Pre term babies are preserved in incubators but due to lack of electricity in many areas, there is another cost-effective care innovation known as kangaroo mother care. The baby is carried by the mother with skin-to-skin contact and frequent breastfeeding) and antibiotics to treat newborn infections.

Birth asphyxia

Birth Asphyxia is where, during difficult deliveries, the baby is born too ‘tired’ and is likely to die from failure to breathe or difficulties in breathing. Nabukeera explains that asphyxia is the medical condition resulting from deprivation of oxygen to a newborn that lasts long enough during the birth process to cause harm, usually to the brain.

“In some cases, a baby may survive, but with damage to the brain which can cause either mental or physical retardation,” she said.

In 2004, this used to be the third leading cause of child mortality in Uganda. It jumped to the second after Sepsis in 2006. But with improved maternal care, sepsis dropped to third leaving preterm and asphyxia leading in that order.

“Most babies breathe spontaneously at birth,” Nabukeera explains. “But, up to 10% require some assistance to initiate breathing. However, there are instances where a baby may fail to breathe or breathe poorly because of obstructed labour, prolonged rupture of membranes, low birth weight or high blood pressure.”

Sepsis

Of all the causes of death in newborn babies, the most preventable is sepsis or infection picked up during birth, from the place the baby is born into or from poor hygiene. The death of a newborn baby, after nine months of pregnancy and tasking labour, is one of the most painful events for parents especially the mother. Yet it can easily be avoided by taking care of infections at and soon after birth.

According to the 2014 WHO figures on Uganda, about 20 women out of 1,000 lost their babies within the first

seven days of life in 2011. And the three biggest killers are premature births (28%), asphyxia and trauma (27%) and sepsis (18%). Of these, sepsis is the most preventable and treatable by large. It can also be controlled by basic hygiene observation and primary healthcare.

What is sepsis?

Associate Professor Peter Waiswa of Makerere University School of Public Health defines sepsis as when the baby acquires a bacterial or viral infection from the mother, the environment or the care givers.

Dr Jamir Mutyaba, a Neonatologist /Paediatrician, at Mulago Hospital explains that when the bacteria go to the lungs, it is called pneumonia and this is most common in the first 7 days. When it spreads to the brain, it is called meningitis and is common after 7 days.

“Once these organisms enter the blood, they can easily spread to vital organs like the liver, kidney, lungs etc because the blood goes all over the body. Remember, newborns have a developing but weak immune system,” Dr Mutyaba said.

At Mulago Hospital where he works, Dr Mutyaba says 37 percent of the babies who present with fevers, convulsions etc., have sepsis. He also noticed that baby boys are more affected than girls.

The good news is that sepsis can be treated. But if medical assistance is not sought, the baby may die or acquire a permanent disability.

What causes sepsis?

Dr Emmanuel Bukalu Zziwa, a reproductive health specialist, says the biggest risk in Uganda is the poor hygiene conditions at the place of delivery.

“Sepsis is common in dirty delivery environments especially for mothers who deliver at home, by traditional birth attendants or in some dirty or crowded hospitals labour wards where the infection control system is not good,” he said. “Practices like health practitioners not washing hands between seeing patients can spread infection, while repeated pelvic or vaginal examination do increase the risk.”

Dr. Margaret Nakakeeto a neonatologist consultant at Kibuli Hospital, says hand washing can prevent infections by 80 percent.

“In fact, every mother should wash their hands as they enter the nursery, before or with 70 percent alcohol

sanitizer,” she said adding that cleanliness should be paramount during delivery as a lot of blood is involved which may increase the risks of infections.

Dr Zziwa, who is also the head of community health programmes at Intercity Health, says babies can also acquire the infection from the mother during birth. Often, they get it from the mother’s uterus. Known as Chorioamnionitis, it is an inflammation of the foetal membranes (also known as intra-amniotic infection) due to a bacterial ascending into the uterus from the vagina.

“Premature rupture of membranes can also increase baby’s risks of sepsis because the leaking liquid is a rich

media for organisms or bacteria to grow”, Zziwa said.

Dr Jolly Nankunda, a senior paediatrician consultant at Mulago National Referral Hospital said when there is obstructed labour, especially when the baby gets stuck, the risk increases.

“The longer the baby stays in the birth canal, the higher the risk of catching infections,” Dr Nankunda said.

Dr Nakakeeto adds that sepsis is rapid and common in babies whose cords are not tended properly. The cord is the commonest route of infection especially when the dressing is very poor.

What mothers can do?

Prof Waiswa, who also heads Makerere University Maternal and Newborn Centre of Excellence, said mothers need good nutrition to boost their immunity which they also pass on to their babies thus helping the babies fight infection. Foods with immunity-boosting nutrients like mushrooms, citrus fruits, seafood, and fortified cereals and breads are good. Try also fruits and vegetables, fish, whole grains and low fat dairy products.

The professor also advised proper antenatal care which gives the mother a package of care including disease check-up (HIV, syphilis), immunization against tetanus and preventive medicines for malaria and anaemia.

“During pregnancy, the woman should get at least two anti-tetanus injections because the tetanus vaccine helps a mother to prevent against tetanus in the newborn,” he said.

Dr Nakakeeto adds that mothers should also be tested and treated, with their partners, for any infection like HIV, Hepatitis B, syphilis and urinary tract infections.

Prof Waiswa also advises on clean cord cutting and care. Cord cleaning should be done daily at

least three times a day or as instructed by the doctor.

“If you cut the cord with a dirty instrument like used scissors, razorblades, knives, it is likely to get infected. Cultural practices of putting substances on the cord can also be a source of infection or contamination,” he says. “The cord can become a source of entry of bacteria into the blood, resulting into sepsis.”

Another strategy is to start breastfeeding the baby as early as possible and breast feed exclusively. Other good early care practices include ability to understand the dangerous newborn signs, like high or low body temperatures, failure to breast-feed, convulsions, excessive crying, yellowing of the eyes and body and others.

“Early care-seeking helps,” Zziwa says. “The moment you know a baby is unwell, go to a qualified health worker. Such symptoms include vomiting, lack of interest in feeding, high temperature, unusual breathing or a rash. Others are if the baby cries excessively, develops faster heart rate than usual, gets a bulge on the head’s soft spot or has decreased amount of urine, rush to the hospital”

Nabukeera emphasises health education in community about care for the new-born at home, feeding and signs of illness among the newborns. This would prevent and also encourage early treatment of new-born diseases.

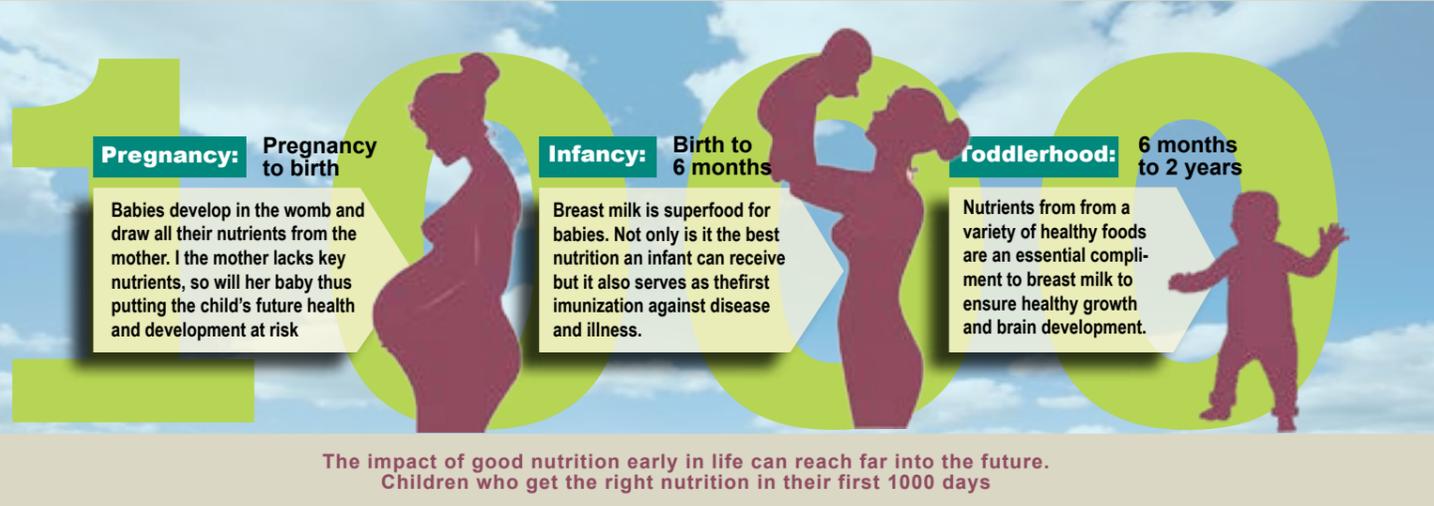
All pregnant mothers should be encouraged to attend to their antenatal visits, which helps in preventing neonatal deaths. This would pick up the potential problematic deliveries. These mothers should then deliver at health centres by skilled health workers.

She said at hospital level, there should be further training of health workers on how to revive the newborn who are born, management of newborn illnesses, and identification of signs which warrant referral.

Health facilities should provide or advise on the necessary equipment for newborn care and resuscitation.

THE POWER OF THE FIRST 1,000 DAYS

The right nutrition in the 1000 days between a woman's pregnancy and her child's second birthday builds a foundation for the child's ability to grow, learn and thrive.



Good feeding creates good baby health

By Angel Nabweteme

Gloria Kirungi, a nutritionist at World Vision in charge of maternal, child health and nutrition, says malnutrition causes as many as 60% of infant and 25% of maternal deaths, sickly children, complications and children with low intelligence.

“Many experts agree that the first 1,000 days of a child are very important in causing or avoiding life-long damage,” she says. “The 1,000 days start from pregnancy up to a child's second birthday. Good feeding during this time, builds a strong immune system in the baby, excellent brain development, smooth labour and few baby diseases and complications.”

Dr Grace Nambatya, the head of research at the Natural Chemotherapeutics Research Laboratories in Wandegaya, says the need for good nutrition begins while babies are still in their mothers' wombs. Adequate nutrition for pregnant women can stem many congenital defects like heart defects, spinal bifida, missing limbs and hydrocephalus.

“Malnutrition in children can be seen in two ways: The first is under nutrition which causes low weight for age (wasting) and low height for age (stunting) or both. The second is overfeeding which leads to obesity and diabetes,” Kirungi says adding that over 50% of children in Kampala are now overweight due to high junk food intake.

Maternal nutrition situation in Uganda

Statistics from the 2011 Uganda Demographic and Health Survey (DHS) indicate that 33 percent children under 5 were chronically malnourished (stunted), 5 percent were acutely malnourished (wasted), and 14 percent were underweight.

The prevalence of stunting was highest in Karamoja (45 percent), children of mothers with no education (19 percent) were more than twice as likely to be stunted as children born to mothers with a secondary school education (8 percent). In addition, children born to undernourished women (body mass index [BMI] less than 18.5) are more likely to be underweight or wasted than children born to well-nourished or overweight women.

Anaemic (lack of enough blood) children were 49 percent and pregnant women, 31 percent. Women in Karamoja (43 percent), West Nile (32 percent), and Buganda (31 percent) regions had the highest prevalence of anaemia.

12 percent of women of reproduction age were undernourished (BMI less than 18.5). Women in Karamoja (33 percent), West Nile (21 percent) and Eastern (20 percent) were more likely to be undernourished. Girls in reproductive age (15–19) were the most malnourished group among women of reproductive age (14 percent). On the other hand, overweight or obesity (BMI 25 or

above) affected 19 percent of women of reproductive age. It increased substantially with education and wealth. The prevalence of overweight was highest in Kampala (40 percent) and the lowest in Karamoja (1 percent)

Nutrition and maternal-newborn health.

The head of Mwanamugimu unit at Mulago Hospital, Dr Elizabeth Kiboneka, says many deaths of mothers in pregnancy and labour as well as their newborn children could be avoided if women were empowered with the proper nutrition information and facilities.

“Malnourished children are ill more often than healthy children,” she said. “They become sicker when they become ill. Some may be very thin and small, others may have swelling of the stomach and feet. It is most common between 6 to 18 months of life. It occurs more frequently around the time of weaning a child from breast milk to other food.”

Dr Kiboneka, says at Mwanamugimu, they admit, on average, 10 -15 new malnourished children daily and 300 monthly.

“The common problems are marasmus, kwashiorkor and beriberi, arising out of either poor feeding or disease. We educate the mothers on nutrition issues, rehabilitate them and their children with high energy foods. We also teach them how to improve their income.”

According to Dr Kiboneka, a poorly nourished woman may have more trouble getting pregnant, more problems during pregnancy, and more trouble delivering the baby. Her baby will be smaller, more likely to become malnourished and may grow up to be a poorly nourished woman with a higher risk of problems with pregnancy and childbirth.

Government action

The Ministry of Health guidelines on childcare calls for growth monitoring in which children less than 1 old are weighed and the results charted on the Child Health Card every time they are immunized. Children who are growing well after 1 year of age can be weighed every 6 months when they receive Vitamin A drops and deworming. Children who are not growing well between 1 and 5 years need to be weighed frequently until their weight improves.

In its Uganda Nutrition Action Plan (UNAP) 2011–2016, Government committed to improve the nutrition status of all Ugandans, with special emphasis on wom-



BREASTFEEDING: A key factor in child survival

en of reproductive age, infants and young children. President Museveni said for every sh1,000 Government invests in nutrition, economic benefits return at least six times more.

“These gains mainly benefit the poor and most disadvantaged, as they spend less money on treating malnutrition-related diseases and increase their productivity, reaping sustainable socioeconomic benefits,” he said

He called upon all district medical officers and others concerned to inform families, through all appropriate media, that a human being needs proteins for body building, carbohydrates for energy, and fats for body insulation, as well as energy, minerals and vitamins.

Breastfeeding practices

Dr Lynne Turyagyenda, a nutritionist at the Mwanamugimu, says breastfeeding is a key factor in child survival.

“Children who are optimally breastfed are three times more likely to survive by the end of the first year of life compared to children who are sub-optimally breastfed,” she says.

Optimal breastfeeding is defined as exclusive breastfeeding for the first six months and continued breastfeeding with adequate complementary foods from six months to two years or beyond. Fortunately, Uganda's culture is positive toward breastfeeding. 98 percent of women initiate breastfeeding of their infants.

For breastfeeding to be effective, infants should be breastfed on demand. This is only possible when babies remain close to their mothers. The UDHS reported that almost all children (96 percent) 0-6 months were breastfed at least six times in the 24 hours before the interview. Only HIV-positive mothers tended to breastfeed for a shorter period. Other reasons why women stopped early included pregnancy, no milk in breasts, the child refused the breast or the mother got sick.

The national guidelines recommend that breastfeeding be initiated within the first hour after birth. Kirungi says this takes advantage of the baby's first hour of alertness and instinct of suckling to promote breast milk production, release oxytocin in the mother which helps contract the uterus and reduce the risk of bleeding after child birth. Oxytocin also helps establish bonding between mother and child.

Kirungi advised mothers to start breastfeeding as soon as possible after birth.

"That first yellow thick milk (colostrum) is rich in antibodies that protect the newborn from disease," she says.

A UNAP document explains that early breastfeeding can reduce the risk of baby death by 16 percent if started on the first day and by 22 percent if initiated within the first hour.

Exclusive breastfeeding

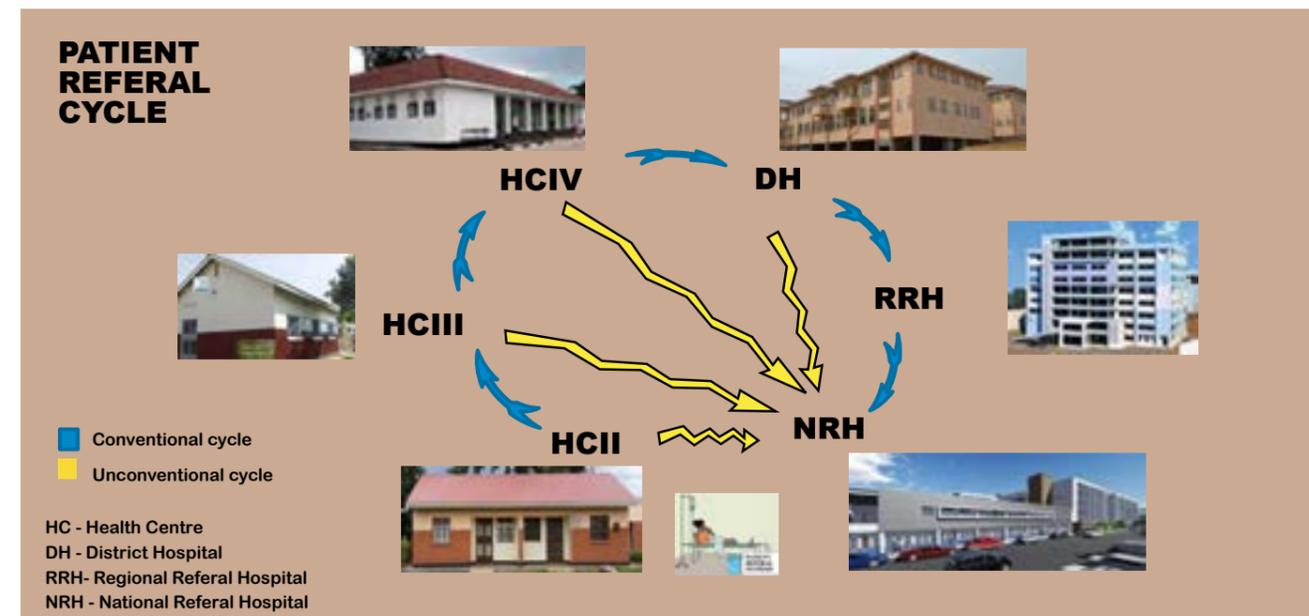
Women with HIV are advised either to breastfeed exclusively or not to breastfeed at all. The Uganda Policy Guidelines on Infant and Young Child Feeding recommend that infants should not be given any fluids (including water) or foods other than breast milk until they turn 6 months. HIV positive mothers are also advised to exclusively breastfeed their infants for 6 months unless they are advised not to by doctors. Infants who are not exclusively breastfed in the first two to three months of life are six times more likely to die of infection than those who are.

However, many children in Uganda are not exclusively breastfed. More children especially in urban centres, are being introduced to other foods and fluids earlier in life because parents need to go for work. Consequently, they substitute breast milk with high carbohydrate and high sugar-content food which only increases the rate of overweight children.

Way forward

Experts advise the following:

- Women of reproductive age (15-49 years) should feed well so that when they are pregnant, they can properly nourish their children from the time of conception.
- You can ensure a healthy, clever and disease resistant child by proper nutrition in the first 1,000 days of a child. Often, you cannot undo the damage done by malnutrition during those 1,000 days.
- Good nutrition leads to problem free deliveries and healthier babies.
- Breastfeed the baby on demand.
- Dr Nambatya says mothers and babies should take advantage of nutrients in fruits and vegetables, like vitamins A, B, C etc, minerals like iron, zinc, selenium etc, and plant hormones, enzymes and chlorophyll, all of which play an important role in the proper development and specialisation of body cells.
- During pregnancy, eat a balanced diet; it prevents complications, helps the baby's brain formation, leads to safer delivery and less illness. Eat more at each meal and add healthy snacks between meals. Take iron and folic acid supplements, drink enough safe, clean water and avoid alcohol.
- After delivery, eat healthy food to regain strength. Take Vitamin A within 2 months of delivery, iron tablets for at least 3 months and drink extra fluids to produce enough milk for the baby.
- When a child is sick, continue breastfeeding because it will help with their recovery, especially if it is diarrhoea.
- If the mother has breast problems that interfere with breastfeeding, like a cracked nipple, rub expressed breast milk into the nipples and let the nipple dry in air. It will heal faster. Use cow's milk only if the pain is unbearable, breastfeeding is impossible, a mother dies or is critically ill and no wet nurse is available.



We need a stronger referral system

By Fatumah Nalwanga

Any health provider that realises he or she can't handle a patient because of skill competence, lack of equipment or facilities, is obliged to refer the patient to a higher and better level. This is a worldwide practice in all health systems. It is logical but, in Uganda, it is not working well. The problems run from bottom (patients) to the top (hospitals) and involves the health system supervisors (government).

What is referral system?

Dr. Nicolette Nabukeera, a senior paediatrician at Shalom Doctor's Clinic in Kampala describes a referral system as: "Where a less skilled health worker or lower level health facility sends a patient to more skilled health workers or a hospital with better facilities."

Stella Kachope, a senior nursing officer from Hoima Regional Referral Hospital, calls it: "When a health worker from a lower level facility sends a patient to a higher level facility for further management of a particular health challenge."

If the referred patients are still energetic, they can find their way to the referred institutions. But if they are very weak, they are supposed to be taken in an ambulance, accompanied by a nurse who is familiar with the mother's or baby's history, a referral letter signed by the head of department and, if necessary, the patient should be on medical attention from ambulance facilities throughout the journey, Kachope says.

Kachope, however, says due to resource constraints, the referring institutions may require the patient to cover the full or part of the cost of referral.

She also adds that the community doesn't understand the referral system.

"Some people think sending them to bigger hospitals means they are badly off and are going to die! Others look at the cost and convenience implications that come with shifting to a hospital much far away from their homes. That is why such a good medical practice is sometimes resisted, often leading to unnecessarily bad consequences," she said.

According to Dr. Jolly Nankunda, a senior consultant paediatrician at Mulago National Referral Hospital, referrals are a normal prescribed and recommended process in a functioning health system. They help the system to use resources efficiently by dealing with the many relatively minor cases at simpler institutions while keeping the more advanced institutions free to deal with the smaller number of cases that are more difficult. They also enable patients access the most relevant type of service available in the whole system.

Challenges in the referral system

Kachope explains that referring a patient is meant to be done in a hierarchical format. The recommended procedure is that Health Centre (HC) II should refer to HC III, then HC III refers to HC IV and HC IV refers to a

district hospital and a district hospital refers a regional referral hospital then the regional referral hospital refers to a national referral hospital for managing complex cases. Sometimes a HC II can refer to a regional referral hospital if they realise that the next level in the hierarchy does not have the equipment or services need to handle a specific condition.

But, she laments, some health workers have not been trained properly to identify when, where and how to refer a patient! Many from HC IIs and HC IIIs refer patients to national referral hospitals when the cases could have been managed at HC IV or regional referral hospitals. This causes a pile up of patients at the national referral hospital. Others refer to the next level unaware that the services required are not available there.

When to refer

Referrals occur when a facility is unable to handle a particular ailment.

“A less skilled health worker will refer a mother or their baby when they realize they don’t have enough skills, equipment, and competence to handle that patient,” Dr Nabukeera says, adding that a hospital may also refer a mother when she fails to respond to treatment.

“For mothers, it must be as soon as they notice that a normal delivery may not be feasible or it may require caesarean section or any other interventions beyond their expertise. The medics must know when to refer mothers to the nearest facility that has better skilled manpower and equipment before labour begins,” Dr Nabukeera advises.

For newborns, she says, it should be after such complications as difficulty in breathing (birth asphyxia), refusal to breastfeed, unexplainable fever, yellow eyes and skin (jaundice) and convulsions or abnormal movements.

“Many babies have died because health workers fail to realise when to refer or misinterpret signs,” she says. “I have seen many newborns with fever being treated as malaria because the facility has no expertise to identify the real problem. By the time they find out the exact problem, the baby is dying.”

Kachope adds that babies born with congenital abnormalities like hydrocephalous are also referred because regional referral hospitals don’t have the capacity to



handle. **AMBULANCE: Essential in a referral system**

“We refer such cases to Mulago National Referral Hospital or any specialized hospital like CURE Hospital in Mbale,” she says. “Other referral cases are cancers, eye conditions, psychiatric cases and head injuries.”

Mulago, the end point in Uganda

Mulago National Referral Hospital receives all mother and child referrals of complicated conditions from all the lower health units. But, according to Dr Nankunda, the referral system has been ignored and Mulago hospital now receives patients who should not be going there.

“Some are self-referrals who believe they can only be handled in Mulago, while others are referred due to lack of supplies that lower health facilities should have. For example children who need blood transfusion, may be referred to Mulago National Referral Hospital simply because the referring facility lacks blood in stock,” she says.

Dr Nankunda adds that some referrals are due to inadequate investigative capacity at the referring unit while others are referred from private or Private Not for Profit hospitals because the patients cannot manage to pay the required fees.

According to Dr Nankunda, Mulago has five senior doctors and 15 nurses specifically assigned to handle newborn children and mothers referred from lower centres.

Referred from Mulago

Although rare, Mulago may also fail to handle and refer mothers and newborn babies to other countries for extremely challenging cases, such as babies with congenital heart defects, transplants, and bone marrow transplant.”

Dr Nankunda clarifies that on referral, patients are given a referral letter detailing out all the investigations done and treatments given in Mulago Hospital, and the patient is escorted by a trained medical personnel to the respective country.

Doctors speak out

The Uganda Medical Association-UMA; are basically the foot soldiers in the implementation of the referral chain. Dr. Fred Bisso, the president, did not hold Uganda’s referral system in high esteem.

“Our referral system is not up to the required level and I would say it is relatively inefficient especially in maternal and child health,” Dr. Bisso confirmed.

The doctor, who spoke on behalf of the association, said the inadequacy ranges right from the lower cadres in the lowest health facilities up to the highest level of policy makers.

“There are many health workers at health centres, who cannot interpret patients’ problems and so, cause false referrals. Or they first complicate the case before referring it. For example, they may mistake symptoms of cancer swellings in babies for abscesses and prescribe antibiotics. After worsening the problem they refer to higher centres,” he explains, adding that health workers also lacking knowledge of where competent health personnel are located.”

Bisso also blames Government for too much laxity in supervising the referral system.

But the biggest pain in the referral system is the transport system, ambulances, blood and oxygen, Bisso said.

“How many mothers and babies are dying due to lack of fully fledged ambulances, bad roads, traffic jams, lack of oxygen and the likes? How many health centres have oxygen plants, ambulances with oxygen or first aid facilities? Mothers die on the way to health centres due to very long distances, very poor roads and lack of transport. Many are carried on heads, others on bodabodas, and bicycles!” Bisso asked.

There is no government hospital that can afford a helicopter ambulance for emergencies, he observed.

Recommendations

Bisso says UMA wants Government to improve competence of primary health care personnel so they are able to quickly recognize immediate referral cases, since they are the first contacts with patients.

“It calls for refresher courses for all cadres to equip them with update information on how, where and to whom the mother or baby should be referred. It will equally help them to know the signs that a mother is in danger and needs immediate referral,” Bisso says.

He also advises that more doctors should be posted to community health centres. All health Centre IVs should be headed by doctors instead of clinical officers. And these centres should be equipped with diagnostic tools.

“Doctors are adequately trained to handle sensitive emergencies. They can also easily detect a problem during antenatal visits, before or even after labour for both the mother and the baby. They know the rightful personnel who can handle emergencies that can’t wait,” he said.

Many government hospitals have ambulances, but they are not enough.

“The ambulance system should be decentralized such that they can be stationed at health centres with more emergency cases, instead of ferrying people for workshops,” Bisso said. An ambulance should be well equipped, well fuelled, on standby and ready to swing in action in case called for emergency cases.

Kachope says from her experience, some of the emergencies are escalated by husbands whom she describes as unco-operative.

“Some men are a disgrace. When a woman is referred, they resist saying they don’t have money,” she says. “Husbands should be part of the pregnancy, right from conception to growing the child into an adult. Encourage and escort the wife to antenatal care, where referral possibilities are detected early and handled. The family must save money because you never know how far the mother can go in being referred to higher level facilities.”



INNOVATION: A nurse helping a mother to use kangaroo care

Saving Uganda's mothers and newborns

By Charlotte Ninsiima

By 2011, Uganda was losing 39,000 newborns annually, with a neonatal mortality rate of 27 deaths per 1,000 live births. 59% of childbirth was occurring outside the health facility without skilled care. This prompted the ministry to outlaw traditional birth attendants (TBAs) and insist that all newborn and mother care should be at hospitals and health centres.

In June 2015, Uganda launched the Every Newborn Action Plan, (ENAP) which had been endorsed at the 67th World Health Assembly. The plan set clear direction for investing to ensure newborn survival and prevent stillbirths. It also laid out targets for countries to meet by 2035. The plan covers essential newborn care on all the three stages of mothering; during pregnancy, around birth and the first week of life:

Care during pregnancy

Professor Peter Waiswa, from the Maternal and Newborn Centre of excellence at Makerere University School of Public Health, explains that newborn care during pregnancy relies on ensuring the woman attends antenatal visits at least 4 times.

“This is for preventive action by monitoring the mother's health,” he says. “It includes blood checkups for HIV, malaria, anaemia, syphilis, blood sugar, hypertension and urine infections.”

According to the Uganda Clinical Guidelines revised November 2012, the main objectives of antenatal care are to prevent and treat any complication, prepare for any emergency, plan the birth as well as satisfy any unmet nutritional, social, emotional, and physical needs of the pregnant woman. Parents are also taught how to care and feed their newborn, how to identify risky situations requiring skilled attention, and the male parents are also encouraged to participate in the pregnancy. The guidelines require health workers to check for anaemia (lack of blood), which is the most frequent and major complication of pregnancy, as well as malaria, (which complicates about 80% of all pregnancies in Uganda) and early vaginal bleeding.

Other components of care include early identification and treatment of sexually transmitted infections especially syphilis and HIV as well as prevention and management of harmful practices like smoking or alcohol use. Mothers are also given life skill education like how to deal with intimate partner violence, getting prepared for birth and anticipating the actions needed in case of an emergency.

Care around birth

In Uganda, Ministry of Health encourages all mothers to deliver in a health facility where skilled attendants can be found. A trained health worker is able to help

the mother during delivery, reduce risks of complications and death and ensure that labour is monitored and common complications like bleeding are prevented or managed.

Babies receive a basic package of care called Essential Newborn Care. This includes immediate drying and adequate wrapping for warmth, care for the eyes, umbilical cord (cutting and tying), and initiation on breast feeding within 1 hour. Babies with complications like prematurity, breathing problems and infections, are identified and managed appropriately.

Assistant Commissioner Child Health at Ministry of Health, Dr Jessica Nsungwa says 75% of newborn death occurs during labour and in the first 24-48 hours after delivery.

“This is due to majorly three causes: Failure to breathe spontaneously (asphyxia), preterm birth complications and bacterial infections (sepsis),” she says

She says mothers are provided with mama kits free by government, which include essential necessities needed at the time of delivery.

Sometimes a baby has to be helped to breathe after birth. Most just need stimulation by rubbing the body but some require resuscitation using room air and a device called Bag and Mask. This simple Bag and Mask ventilation is applied to the baby's mouth and nose to support breathing until baby can breathe spontaneously.

Most babies are born full term or after 37-42 weeks of pregnancy. However over 13 out of every 100 births are too soon (preterm) and these babies need extra or special care because they are more prone to such complications as breathing problems, feeding difficulty, poor ability to regulate temperature and infections. For the mother in preterm labour, medicine can be given to them during labour in order to quicken babies' lung maturation.

Care in the first week and month of life

Dr. Jamil Mugalu, head of Special Care Unit at Mulago, says essential newborn care has reduced baby deaths from 33% in 2003 to 19% today.

According to Dr Nsungwa, a baby has 8 times risk of dying when it loses its mother. Thus post natal care is also for the mother. This care should be offered starting immediately after delivery, at 6 hours, 6 days, 6 weeks and 6 months.

Care for the mother mainly involves preventing and

managing bleeding, identification and treatment of infection, adequate rest and nutrition.

Care for the newborn is initiated at the facility and continued at home. Mothers and their partners are usually taught key practices such as continued cord care and hygiene, providing warmth, nutrition through breast milk and identification of danger signs like fever, seizures, yellowing of the eyes and failure to feed.

Dr Mugalu says good umbilical cord care prevents infections.

“Women are advised on how to keep the cord clean and infection free until healing and how to use an antiseptic called chlorhexidine, which is encouraged by WHO. We discourage them from applying traditional substances like herbs, cow dung, clay, onion, and soot among others. We also warn them against removing the cord forcefully,” he said.

In cases of preterm babies and small babies, an innovation known as Kangaroo Mother Care (KMC) can be initiated in the hospital and continued at home. KMC is where the small naked baby is placed on skin-to-skin contact with the mother (between the breasts) or care taker and wrapped in warm clothing. This position ensures optimal body temperature is maintained for baby and encourages bonding between mother and baby. Dr Mugalu says frequent breast feeding on demand is an essential part of KMC.

Mugalu also talks of nutritional care. Exclusive breastfeeding is always encouraged. The normal weight of a healthy baby is between 2.5kgs to 3.8 kgs. Babies who weigh below 2 kgs require a Total Parental Nutrition (TPN) that contains fats, carbohydrates and glucose, and protein for their wellbeing. Also a medication known as surfactant is prescribed to newborns weighing 1kg and below to help expand their lungs to ease breathing, he said.

However, in spite of these elaborate guidelines, Uganda still loses many newborns and mothers either due to lack of facilities and drugs, delays to receive care, too busy or exhausted health care providers and failure of the referral system. We also still have a lot of parents who only go to designated health facilities as a last resort, after complications have set in.

Dr Waiswa says Government need to allocate more resources to improve not only facilities like equipment, labour wards and operating theatres, but also skilled staff in terms of obstetricians, midwives, neonatal nurses and others.



PROFESSIONALISM: Nurses train in customer care as an essential deliverable

Customer care at hospitals

By Angel Nabweteme

Midwives and women giving birth participate together in one of life's greatest miracles but, all too often, they share more anger rather than joy. A little understanding – on both sides – could help improve the situation and possibly save lives in the process.

Studies by the Ministry of Health show that the majority of women in rural areas don't deliver at hospitals and health centres, many preferring traditional birth attendants (TBAs). The studies quote some women as saying it is because TBAs give better customer care while the skilled attendants in designated delivery centres tend to be rude, have a bad attitude and are impersonal in their approach to mothers.

For instance, in Kabale, on realising that in Rukiga, one of the four counties, nearly one in every two mothers that use TBAs died, the district passed by-laws to penalise those who deliver at TBAs. But women still risked the services of TBAs saying TBAs offered motherly care unlike in the health centres where the nurses are abusive.

So, why are midwives failing to ensure customer care for mothers? What can be done to improve customer care at health centres? What should mothers do to en-

sure their rights are respected?

What are the causes?

Apparently, mothers have a hand in lack of customer care and in enforcing it. A midwife who preferred anonymity said many health care providers get rude as a reverse reaction to the mothers' attitude, cowardly practices which threaten baby survival and due to lack of co-operation.

"Midwives are trained, yes, but above all they are human beings. If mothers cannot stay in their skins during delivery, how do they expect nurses to? Sometimes mothers need to behave in a way that can entice a midwife handling them to be good too," the nurse with 15 years of experience in midwifery said.

Sister Catherine Batuuse, a lecturer at Mulago School of Nursing and Midwifery, blames bad attitude on the current generation of people who are not properly brought up. She says modern parents leave their children's discipline to schools, which in turn do not care.

"By the time a girl is entering nursing school, her attitude is bad and the few years at school are not enough to redeem her into a good nurse. Nursing is a call from

God to save life," says Batuuse who has been in nursing for almost 50 years.

She believes a good nurse must be compassionate and customer care is a pre-requisite.

"We train them that customer care is among the basic and core values. They can't handle patients when they have bad attitude, are impatient and not empathetic at all."

She also blamed those who chose to be nurses because of the financial expectations and not the passion for saving life.

However, asked if, in her entire nursing life, she had never been rude to a mother, Batuuse said there is a difference between being rude and being stern.

"A little motherly harshness is good for the mothers, especially those who are spoiled and stubborn," she adds. "If you decide to be lenient, 50 percent of the babies will die. As long as you are aiming at a live mother and a live baby, you have to set the rules in a tough but respectful way. My main aim is to save the baby and the mother but sometimes, the mothers' main aim is to get less pain and that is where we clash."

Frank Malibu, a student at Mulago School of Nursing and Midwifery acknowledged that customer care is taught in the first semester under code of conduct, ethics and etiquettes.

"We are taught about patient's rights like privacy, confidentiality, equal treatment and how to be empathetic. But we are still human beings," said Malibu.

"In situations of pain, the mothers have a tendency of self-preservation which may threaten the safety of the delivery. It may be understandable that some midwives will shout and scold mothers, especially those who do not want to co-operate with them."

Another nurse, who preferred to be referred to as Nambi, narrated how she handled a woman with disabilities who was having a second baby. She advised her against having another pregnancy and she took offence.

"She started arguing that she was also a normal woman. I lost my cool and told her off that she was not! Later my supervisor said I was rude," Nambi said.

Nambi says nurses may be taken to be rude because of



GOOD CARE: A nurse helps a new mother at Case Clinic in Kampala

personal frustration with work, home, love or finances. Their work load is heavy - you don't expect a nurse who has had to deliver 20 babies to remain calm with 5 more coming-, unco-operative or stubborn mothers and belittling gestures from some delivering mothers.

She therefore asks mothers to also be respectful to be accorded the same and not to treat midwives as their servants as some do. What may pass as rude often arises from a reaction to pain, fear and stress. Mothers often provoke bad reactions from midwives due to the same psychological reaction to stress.

However, Fredrick Isingoma, an administrator at Uganda Nurses and Midwives Council (UNMC) says under no circumstances should any nurse or midwife mistreat, belittle, abuse or ignore a patient.

Uganda Nurses and Midwives Council is a body that licenses and superintends all nursing work in Uganda.

"Customer care is key in quality health services. Any person who cannot exercise patience and professionalism should leave the nursing profession. Nursing is not just any job that makes you money," he said.

He believes nurses must have the passion to save life - as it is 'a calling from God to love and care for His people

who are in pain.’ He adds that training schools add skills to people already called by God, to enable them handle mothers professionally.

The nurses regulatory body does not tolerate anybody who humiliates, is rude, abandons or treats patients with attitude and they encourage mothers who feel they have been mistreated to report the case. All health providers have name tags and it is easy to make out the supervisors.

“If the supervisor doesn’t help, contact the administration. If nothing is done, contact the political heads in the region. If still dissatisfied, come to us. We have a disciplinary committee and a code of conduct with specific punishments which include retraining, compensation for the mother, up to de-registration,” says Isingoma.

He encourages mothers to give feedback to improve the midwifery practice and not to put the next mother at risk of torture.

“Don’t fear that the midwife will lose her job, no! It is intended to help her improve.”

Batuse advised that when giving feedback, it’s helpful for mothers to have evidence like the name of the care giver and appealed to parents to play their roles in bringing up children in a responsible way so that they can have courtesy and respect for elders.

Batuse also called for the return of confidential reports which were abolished. Previously, supervisors were required to record their observations for discipline and grooming in confidential reports but it was changed for open reports that make it harder for one to point out misconduct.

“The supervisor doesn’t want to antagonize a fellow worker and in the end, a rude worker is not helped.”

But Nambi insists that customer care can’t improve without addressing structural problems. “It is why nurses in good private hospitals behave well. Nurses’ working conditions, remuneration, motivation and social support need to be improved,” she said.

I did not like the way I was treated

As told to Angel Nabweteme by Nakalumba Priscilla

I still remember the 22nd of July 2014. I delayed to arrive at Mukono Health Centre IV to deliver my first child. The three midwives on duty abused me for coming late without knowing why I had delayed. The only surgeon around couldn’t operate on me because he said he was tired; he had been working the whole day. Nurses just told me to either wait for death or find quick means to Lugazi Hospital.

My mother and relatives started crying. We made a call to Mukono dispensary and they sent an ambulance to fetch me. We arrived at Lugazi hospital without a medical card because the nurses in Mukono had misplaced it.

At Lugazi hospital, the health workers threatened to abandon me because I had no medical card. They charged me sh250,000 and told me to get on the bed. When I complained that the bed was full of blood, the nurse told me to go home and bring mine.

She inserted a tube in my urethra so roughly that I screamed. She scolded me saying she was not my husband and then ordered me to walk naked to a stretcher in the corridor. When I suggested that the stretcher be brought to me instead, she barked at me asking if I was the queen of Buganda. As I staggered to the stretcher, my mother hurried to cover my nakedness but the nurse stopped her.

When the nurse made a mistake looking for my vein and I complained, she threatened to let me treat myself. Fortunately, my baby was retrieved successfully but I was in pain! I asked for pain killers but was told ‘I shouldn’t have opened my legs’ if I didn’t have the nerve to handle the consequences.

I was shivering from too much cold in the theatre but feared to say anything else because of the nurse’s bad attitude. The private room they gave us was so dirty, with no water, the toilets were not flushing and yet I had a baby! I dared not say anything because I knew I would be shouted down! Up to now I fear having another baby.



UP THE HILL: Kisoro’s terrain makes it unpopular to health workers

Hard to reach: Busanza in Kisoro

By Lilian Namagembe

One of the car tyres almost burst on hitting a pothole as we sloped to Muramba Health Centre III, which is 25km away from the South Western district town of Kisoro. A failed attempt leads us to another health centre IV, 7km away. From Mpaka border post which separates Kisoro district from the DR Congo.

Accessed through a rutted road, Busanza Health Centre IV is made of four tired glassless window structures, etched between four thick hills.

We are on a spot visit to the facility on a shiny Tuesday afternoon. We find Aggrey Byangana, the acting in charge and the only health worker, attending to patients in both the female and male wards. He is a clinical officer.

Byangana laments that out of the 15 health workers, only three are accommodated at the facility, which leads to high absenteeism as others need to trek kilometres every morning to come to work.

“I have to spend Ush 15,000 every day on fuel to travel from [Kisoro] town where I stay,” he says.

The insecurity at the fenceless centre, surrounded by thick hills with no electricity is a considerable challenge for health workers assisting in delivering mothers at night.

“The only solar panel at the maternity ward is worn out and ineffective,” he said. “We don’t have a functional operational theatre that is supposed to be at Health Centre IV. And without an ambulance to transfer patients to the district hospitals 25km away, a number of mothers and newborns end up losing their lives while the lucky ones survive with lasting complications due to delayed labour.

Byangana says the centre is very busy, handling about 500 patients on a daily basis.

“I have to work 14 hours daily from 8am in the morning if I am to treat my daily target of 50 to 60 patients,” he says, adding that he often does this on an empty stomach.

He has to get his meals kilometres away from the health centre which makes it hard for him to have lunch and breakfast.



Community training at Busanza Health Centre

“Like today, I have not had a meal since morning,” he laments.

Unlike urban areas where public hospitals are complemented by private health facilities, people in rural areas depend heavily on government health centres and hospitals for treatment. The location near a border post attracts hundreds of refugees especially on market days of Tuesdays and Thursdays. Staff is overwhelmed on those days.

Wilson Tibigyenda, the Kisoro Chief Accounting Officer, blames the rugged terrain for the district’s inability to attract and retain health workers.

“As a result, we have very few health providers with a heavy workload at all facilities,” he said.

According to the World Health Organisation (WHO), in 2013, there was one doctor for every 24,725 Ugandans and one nurse for every 11,000 patients. WHO recommends one doctor per 1,000 people. The shortages are worse in rural areas where 80 percent of the population resides, as 70 percent of all doctors are practicing in urban areas.

Tibigyenda said the district always advertises for doctors and gets no response. And these challenges the poor health working conditions in other hard to reach districts across the country.

Doctors often cite heavy workload, poor facilities, lack of electricity, lack of safety, lack of drugs, poor accom-

modation, poor accessibility and lack of motivation through promotions and transfers, among others as disincentives to work upcountry.

Hard to reach policy

The Ministry of Public Service introduced the Hard to Reach Policy of 2010 to provide incentives for all public officials working in hard to reach areas. These were defined as areas which are remote, insecure, and with poor infrastructure. 22 districts, including Kisoro, were identified as hard to reach and hard to work. According to the policy, staff who work in these districts get an additional 30 percent of their monthly salary as hardship allowance, and also receive transport and

food allowance.

But these don’t seem to have been enough for the local governments in the hard to reach districts to attract and retain health workers.

Even in districts that do not qualify as hard to reach, as long as they are off the main roads, health workers still find it unattractive to work there. At Nakoma Health Centre IV in the eastern district of Bugiri, Dr Geoffrey Kasaizaki the in charge, says for years, the district has failed to recruit a radiographer despite the repeated adverts for the post.

“It takes a bold decision for one to come and work in such an area with poor accommodation facilities,” Kasaizaki said.

Dr Ismail Mugambwa, a medical surgeon at one the private hospitals in Kampala, says he would only accept a government job to work in Mulago National Referral Hospital which is well equipped.

“I have issues with hospitals in remote areas; most of them lack even the smallest equipment like sterilizing machines!” He says.

Being youthful, Mugambwa finds it hard to settle in a remote district where there are few good social amenities such as entertainment centres and electricity.

According to the Health Service Commission, most of the trained medical students prefer consultancy jobs in



A patient being carried to hospital on a make shift stretcher

Non Governmental Organizations where working conditions are better than in rural government health facilities.

Prof. Pius Okong, the Health Service Commission Chairperson, says out of the 5,000 registered doctors in the country, only half of these are practicing medicine.

“And even half of those are practicing [medicine] in urban areas,” Prof Okong states, adding that two out of three doctors are in Kampala and very few of those practicing medicine in rural areas are junior doctors.

Districts in hard to reach areas, he says, cannot attract specialists and other medical officers because there are no opportunities to promote them which makes the incentives unattractive.

“District health systems need to be recentralized so that there are opportunities for doctors to be transferred at one point in urban areas,” he notes.

At the moment, Prof Okong says, once one is recruited in a remote area, they are stuck there for the rest of their lives.

However, Ministry of Health says that the challenge of poor working conditions in remote areas is a bigger economic problem beyond the ministry’s docket.

Dr Asuman Lukwago, the former permanent Secretary says compensation did not improve the attractiveness of the areas. He advises instead that working conditions of the health workers in remote areas need to be developed.

“It is a big structural problem. They [health workers] need good nursery schools, roads entertainment centres and other amenities for their families,” Dr Lukwago remarks.

Analysts reason that it will always be hard to get doctors because of the school system in Uganda. Admission for medical school sieves off the best academically who also happen to have studied in very expensive schools. That means their parents are wealthy and can afford higher tuition fees. These rich family kids are used to electricity, flowing water, TV, and a comfortable lifestyle. Many find it hard to settle in rural areas.

Dr Lukwago says the ministry tried to create special scholarships to train students from remote areas as doctors. But once they tested the greener pastures of urban areas, they too found it hard to settle in rural areas.

Figures obtained from the Ministry of Public service indicate that medical officers in Uganda are paid a gross salary of Sh846,000 consultants earn about Sh1.3m while senior consultants earn a gross salary of Sh2.3m.



IMPASSABLE ROADS: Bridges are often washed away impairing transport in Hoima region

Remoteness problem in Hoima

By *Precious Naturinda*

Maternal and newborn health has no patience with a sluggish transport sector. Impassable roads, few and ill equipped ambulances, distance to hospitals and health centres as well as big population to health centres' ratio all affect services to mothers. Yet that is an adequate description of Hoima referral area.

The Hoima Regional Referral Hospital Director, Dr. Francis Mulwany, says shortage of ambulances in the region is among the leading contributors to maternal and newborn deaths in the region and at the hospital. "Many don't show up, and those who do, arrive when it is too late to save them or their babies," he said.

The region

Hoima Regional Referral Hospital is estimated to have a catchment population of about 3 million people. It receives patients from districts of Hoima, Masindi, Kiryandongo, Buliisa, Kibaale, Kyankwanzi and Kiboga. Others come from the Eastern DR Congo areas.

These are remote areas, with poor road network and vehicle shortage. Mulwany says most of these districts have only one ambulance stationed at general hospitals. Some are sometimes not functional and so, most patients use public transport which may lead to prolonged labour and death before the reach the hospital.

Dr. Rachael Nanziri, a gynaecologist at Hoima Regional Referral Hospital, says about 80% of rural women live more than 5km from the nearest health units.

Mulwany calls it a challenge.

"Patients come late and sometimes when little can be done. The region is big, the roads are bad and most health units, including cealth centre IVs, have no ambulances!" he said. "Think of someone coming from Buliisa, deep in Kyankwanzi, Kibaale or in Kyangwali; by the time she hires a vehicle; which is also hard to get in some areas, the patient is in problems."

The director also notes that most mothers need emergency obstetric care like surgery and blood transfusions which are also sometimes a challenge. That is partly why newborn and maternal deaths are still high at the facility.

"The leading cause of mothers who die while giving birth include severe bleeding, infections, and obstructed labour, among others which normally occurs in mothers between 20-39 ages. Many cases can't wait! Like loss of blood or ruptured uterus! The patient needs to be delivered fast to hospital.

Facilities

Hoima Regiona Hospital has only one ambulance that is meant to refer patients to Mulago yet it is also dilapidated and breaks down very often.

"We got it in 2007. It has only one small oxygen cylinder and no monitors. At its current rate of breaking down, it is hard to maintain. We spend about 5million Uganda shillings per quarter to maintain it yet the total amount we receive to maintain all vehicles in the hospital is about 10m Uganda shillings."

Hospital statistics

The average deliveries at the hospital per month are estimated to be 650-800. The hospital lost 25 mothers and 120 babies out of 3,251 deliveries in a period between January to June this year. And last year (2015) from January to December, 44 mothers and 331 babies died out of 6,350 deliveries.

Statistics revealed by Dr. Tom Ediamu; a senior cConsultant paediatrician at Hoima Regional Referral Hospital, also show that an average of 150 newborn babies die per year in the 5 general hospitals of Hoima, Kiboga, Bulisa, Masindi and Kagadi. The leading causes include prematurity, birth asphyxia (baby fails to get enough oxygen), sepsis (infection) among others

Ediamu notes that teenage pregnancy is one of the lead factors contributing to high number of premature babies. He says between 10 and 15 premature babies admitted at the hospital are mothered by teenage mothers. And that teenagers are at high risk of dying if they do not give birth from health units because their pelvic parts are weak as this can lead to over bleeding.

Mulwany urges the government to equip health units and recruit human resource to improve on maternal and newborn health.

"Lower health facilities especially health centre IV should be equipped so as to handle emergence caesarean section. We need an ambulance at every facility at least."

Mulwany says they are trying their best to improve maternal and newborn health by increasing the number of midwives to handle emergencies as quick as possible and have also equipped the neonatal unit.

Save the Children joins in

Save the Children, in partnership with Ministry of Health, has also established a Regional Learning Network aimed at improving the survival and health of mothers and babies in Hoima Regional Referral Hospital.

Berina Kamahoro, the Senior Project Officer at Save the Children, says the network supports mothers to ensure safe delivery. It also improves health services in health centre IVs and general hospitals so that they are able to handle some of the cases without being referred.

The network will operate in Bulisa Hospital, Bulisa HC IV and Biiso HC III in Buliisa district, Kigoroby HC IV, Kikuube HC IV and Hoima Regional Referral, Bwijangi HCIV and Masindi Hospital, Kagadi Hospital and Kibaale HC IV

Dr. Mulwany is optimistic that it will help in equipping health workers with knowledge and increase community awareness on use of health facilities.

Kiiza's Story

Lupa Kiiza, 19, was lucky she made it to Hoima Regional Referral Hospital where she delivered a bouncing baby boy. Being her first pregnancy, she was not aware of labor pains. When she developed abdominal pain, she rushed to the nearest health Centre II and was given some tablets to reduce the pain. Shortly after, she developed convulsions and dizziness.

"I found her at the health centre in a pretty bad shape," Mawanzo Tabu, her caretaker narrated. "Her husband had gone fishing, so we had no money or way of contact. I rushed to the area LCI chairman who collected money from people and gave it to us. By the time we reached Kyangwali, she was already unconscious."

From Senjojo, a remote landing site on Lake Albert, they had to use a boat to get to the road that connects to the nearest Kyangwali HC III. She needed cesarean section but the facility has no theatre. So they again referred her to Hoima regional referral hospital; a distance of about one and a half hours. Luckily enough, there is an ambulance for Kyangwali refugee camp.

Sr. Constance Aseru, the In-charge Maternity Ward at Hoima regional referral hospital describes Kiiza's condition at that time as Eclampsia; high blood pressure in pregnancy, which is one of the major causes of maternal death.

Aseru says when they arrived at Hoima, she was immediately rushed to the theatre.

Nakazibwe's Story

Racheal Nakazibwe, 21, of Kigando in Kyankwanzi district, was not so lucky. She lost her first born at Hoima Regional Referral hospital. Her mother, Juliet Atimangosaid they had spent a week at the traditional birth attendant place.

"The condition was worsening. We hired a bodaboda to the main road, about 7 km, where we got a taxi to here." Atimango narrated. "We shouldn't have delayed to come. I take a blame for the death of my grandchild. If we had delayed any further, the mother would have died too. But it's a lesson," she added.

Komweru Diana, the In-charge for Post-natal ward says the baby died of fatigue and they had to take her for cesarean section to remove the baby.



A MOSQUITO NET: Government distributes free mosquito nets to pregnant mothers

Gains for mothers and newborns

By Jael Namiganda

On December 10th 2010, Jennifer Anguko a district councilor died in Arua Regional Referral Hospital when her uterus ruptured after 15 hours of obstructed labour. The hospital handles obstetric emergencies for a region of almost three million people but Anguko bled to death. The hospital later admitted that only one midwife was on duty that day and no doctor examined Anguko for 12 hours.

An obstetrician who investigated the case said Anguko, a mother of three, arrived in time and her case is a tragic result of the systemic weaknesses in the public healthcare sector, including inadequate human resources, medication and referral system.

Our national policy promotes maternal health through informed choice, service accessibility and improved quality of care; all these attained through the national Safe Motherhood Programme (SMP). However, it remains a challenge to government having failed to achieve its 2015 Millennium Development Goal of reducing maternal and child mortality rates and achieving 100 percent births attended to by skilled health personnel.

Nevertheless, government has not been 'sleeping'. The acting commissioner for reproductive health, Dr. Di-

nah Nakiganda Busiku says government interventions have included policy changes, improving staffing levels, facility care, community based service delivery through Village Health Teams (VHTs) and changes to essential drugs and commodities.

As a result, between 2000 and 2010, Uganda's neonatal mortality rate reduced by 15.6 percent per year from 32 to 27 deaths per 1000 live births. Although this is slower than national reductions in maternal and 'under five' mortality, it is greater than the regional average rate of decline.

"We gave it a new attention and started with policy change for newborn health through a national newborn steering committee, Nakiganda said. "The committee was given a mandate by the ministry of health to advise on newborn survival issues since 2006."

The commissioner says there has also been an intervention of infrastructure developments to enable a good working environment for the health workers. This has also been followed by essential medicines and supplies at the health facilities.

The private sector has also been strengthened and catered for in terms of supplying them reproductive

health drugs and equipment to enable them provide basic and comprehensive emergency obstetric care.

By the 2011 Uganda's Demographic and Health Survey, as many as 95 percent of women were receiving antenatal care from a skilled provider at least once, 57 percent delivered their babies in a health facility under the supervision of a skilled provider and 33 percent of the mothers received a postnatal check-up within two days of birth.

Dr. Charles Kiggundu, a Senior Consultant Gynecologist at Uganda's National Referral Hospital, Mulago, confirmed that deliveries at the hospital increased to three times more than before.

However, Health Ministry's Commissioner Community Health Services, Dr. Anthony Mbonye noted that Uganda still has a lot to do to improve maternal health care services and reduce child and maternal mortality.

In 2013, in the effort to achieve the Millennium Development Goal, government together with partners developed the sharpened Reproductive, Maternal, Neonatal and Child Health (RMNCH) plan. It was majorly focused on advocacy, resource mobilization and prioritization of high impact interventions to reduce maternal and child mortality. The four year plan expected to save an additional 120,000 children and 6,100 women giving birth by 2017.

The minister for Health, Dr. Jane Ruth Aceng said the target was to reduce the under-five mortality rates from 90 deaths per 1,000 live births in 2011 to 53 deaths per 1,000 live births and maternal mortality rates from 438 deaths per 100,000 live births in 2011 to 211 deaths per 100,000 live births, all by 2017.

The plan's aim was to strengthen accountability and monitoring, partnerships for social mobilization as well as funding and technical assistance. Aceng said the plan emphasized evidence-based high-impact solutions, increased access for high-burden populations and geographical sequencing. Other areas are addressing the broader multi-sectoral context and ensuring mutual accountability for Reproductive, Maternal Newborn Child and Adolescent Health outcomes.

Although Makerere University's Dr. Waisswa Peter, says the plan has actually never been implemented fully due to funding issues, there has been random implementation of some areas.

"Some partners including UNICEF and USAID have supported some projects in high burden regions for instance empowering some community and district to scale up the CODES project. This aims to demonstrate that improved targeting of interventions to match disease burden, and regular review can improve district

health team performance. It also uses evidence-based management tools and focal funding to overcome management bottlenecks.

Thus, there has been improvements in both coverage and quality of key interventions to reduce child deaths from diarrhea and pneumonia.

Another project is the Saving Mothers Giving Life (SMGL) project in South Western and Northern Uganda. It is putting in place such key interventions as high-quality, safe childbirth services, focusing on the critical period of labour, delivery and the first 48 hours to improve maternal and newborn health across 10 districts. This initiative is said to have reduced maternal mortality by 45 percent in facilities and 41 percent in the communities. The ministry also says it has strengthened its interventions to save newborns in all 10 learning and scale-up districts.

Dr. waisswa thus commends the strategies but calls for more strategized effort in bringing the alarming figures even further down if government is to realize the dream that no woman dies giving life in Uganda.

With so many Jennifer Anguko case scenarios, all concerned stake holders must stop at nothing until the set target is realized though for now this seems a dream so far from our reach yet every time progress is made it seems to slip even further away.

SMGL statistics			
Institutional maternal mortality ratio	534 : 295	▼	45%
Community-level maternal mortality ratio	452 : 264	▼	41%
Institutional delivery rate	37% : 28%	▲	33%
Direct obstetric case fatality rate	2.9% : 1.65%	▼	44%
Cesarean section rate	6.9% : 5.3%	▲	31%
Perinatal mortality rate	39.3 : 37.3	▼	5%
Institutional neonatal mortality rate	8.4 : 7.9	▼	6%
Women receiving ARVS for Prevention of mother to child	87% : 85%	▲	3%

Source: A document from the ministry of Health.



COUNTING: Many hospitals now know where to invest by finding out the common baby killers

Counting the dead: Will it be helpful?

By Flavia Nassaka

The World Health Organisation (WHO) recommended that all maternal and newborn deaths be recorded and reviewed so that countries can keep track of their quantity and causes, and use the information to design mitigation measures. This exercise is technically referred to as Maternal and Prenatal death reviews.

Dr. Livingstone Makanga, a Principal Health Officer in the Reproductive Health Division at Ministry of Health, coordinates these reviews at the national level. He said government records every death of a baby 28 weeks before delivery (still birth) to 28 days after delivery which is technically categorized as a perinatal death. They also record the death of mothers, from pregnancy up to 42 days after delivery. All these are known as maternal death.

“These deaths are notified within 24 hours either through MTRAC, an ICT platform used on a mobile phone where they get SMS alerts or through their team members at the health facility,” he said. “Within 7 days, an audit of the deaths is done to review the circumstances including whether a mother attended antenatal, whether it was delay to access a health facility or negligence on the side of health workers.”

The doctor adds that districts have to present a report

to the Ministry by 7th day of every new month.

“Recently, we are adding in a new aspect where even deaths that occur outside a health facility are recorded through the Village Health Teams (VHTs) which are regarded as health centre I in our health system,” he said. “These members of the community are chosen to provide first aid and link patients up with healthcare providers at upper health centres. Because these live within the population they are better placed to know when a death occurs.”

Phiona Abaasa, a public relations coordinator at the Health Monitoring Unit of State house, says the president has also requested that the figures be availed to his office for monitoring purposes. She adds that without the addition of figures by VHTs, it was impossible to capture the real figure of maternal deaths.

Dr. Patricia Pirio, the Programme Manager Saving Newborn Lives at Save the Children, Uganda, agrees with Abaasa on the role of VHTs because the system of recording deaths by the civil registration of births and deaths department is not functional.

Currently Pirio says stakeholders like Save the Children are working with government to train facilities and



MOTHERS' JOY: Lives births are always a pleasure to all stakeholders

VHTs on the new guidelines of maternal deaths audits. She says the system needs to be able to follow up all deaths including those that happen outside the health system like at home.

However, while Dr Makanga said his National Maternal Perinatal Death Review (MPDR) committee has been religiously recording these deaths over the last five years, he couldn't give details of the total deaths registered every year and their variations. The figure of maternal mortality rate of 438 per 100,000 live births and perinatal death of 27 per 1000 births, which he gives, are from the 2011 National Demographic and Health survey. Could it be because of the great disparities?

WHO warns that the system's efficiency needs to be improved because official reports usually underestimate the true magnitude of maternal mortality by up to 30 percent worldwide and 70 percent in some countries. Nearly all stillborn and half of all newborn deaths are not recorded in a birth or death certificate in most countries. Thus they are never investigated by the health system.

Pirio explains that health workers may not reveal figures because they may be scared of the legal implication of their action.

Dr. Nathan Kenya Mugisha, a former Director of Health Services at Ministry of Health, said the intention of these reviews was not to be punitive but to have a complete record for evaluation purposes, understand

the common causes and deaths and thus, measures to stop such tragedies from happening again.

Asked whether the National Maternal and Perinatal Review strategy he helped to formulate was being followed, Mugisha said: “I don't know whether the reviews are being done as was recommended but what I know is deaths have decreased because the review system helps institutions focus on the causes and thus, improve care.”

Mary Nalubega, a health worker at Kyarusozzi Health Centre IV in Kyenjojo District, said they are mandated to discuss each death, mostly chaired by the in charge, to establish what caused the death and how it could have been avoided. She says most of mother deaths at her facility are due to over bleeding and as a measure, they resolved to have a lot of blood at Kyarusozzi because accessing the nearest bigger facility may not be easy with challenges of transport. She however says that although these resolutions are sent to the district health committee, nothing seems to happen as a response.

Dr Mugisha says the system is still being perfected. In WHO's recent publication, *Time To Respond: a report on the global implementation of maternal death surveillance and response*, helps countries strengthen their response period.

Abaasa said although her unit is not directly involved in auditing maternal and prenatal deaths, they receive the figures. She says the number of child deaths are reducing as more mothers are now enrolling for antenatal care and also deliver at the facility.



AT WORK: TBAs were banned in 2010 but many mothers still prefer their services

Why mothers still vote for TBAs

By Beatrice Nyangoma

It is 8 am and I ask one of the motorists to direct me to any of the renowned traditional birth attendants (TBAs) in Jinja District. I was dropped at the one nearest in Bugembe Trading Centre.

She is called Mama Nsiima, and lives in a semi permanent house with a large compound and a sitting room that also acts as her waiting room. There are four pregnant women waiting for her.

I can hear the conversation in the next room; she is explaining to her client that the baby's position is not good. Mama Nsiima then calls out to her grandson to make some herbs for the client.

After the other women are attended to, I am next. She greets me with a lot of respect and motherly concern.

"I have lost count of how many babies I have delivered since I started," she says, "maybe one hundred or two hundred."

When I ask why women prefer her services, she refers me to one of her clients who has just come in, to give me an answer. Mama Nsiima has helped Naigaga Fazira deliver all her four babies and she had returned for consultation with the fifth pregnancy.

Naigaga narrates her ordeal at a health facility she went to and concludes that she will never go there again. "It was my first baby. I went to hospital as soon as labour pains started. It was a Saturday. Most of the nurses were absent and the few around never paid attention

to me. I would feel the baby coming and I call on the nurses but they instead insulted me saying that I was shouting too much," she said. "In the same ward, there was an elderly woman attending another patient who checked on me instead and shouted at the nurses that I was carrying a lifeless baby. That is when the nurses started panicking."

She notes with sadness that had she opted for Mama Nsiima in the first place, her first born would not have died.

Mama Nsiima is aware of the Uganda policy banning TBAs. Previously, the ministry of Health considered them as partners and trained them in skills of handling pregnant women, hygiene, when to refer and how to keep records. But in 2010, Government terminated the collaboration as recommended by the World Health Organization and the Safe Motherhood initiative. All TBAs were banned and the trained ones were recruited among the newly formed village health teams (VHTs), if their respective communities selected them.

But Mama Nsiima says women still come to her. She tried to chase them away but realised that Government had no capacity to handle their demands. TBAs still remain the main source of care for pregnant women, attending to approximately 47–52 percent of all deliveries in some remote districts of Uganda, according to studies by health ministry.

It has been argued that the generally poor functionality of the health system means that TBAs will continue

to remain a source of care for many especially in rural areas of Uganda.

Mirembe Jean Frances, the Jinja District Officer in charge of maternal and child health says they cannot arrest TBAs because they have closed a gap in areas where there are no health facilities or midwives. Even where facilities exist, there are still several barriers women in the communities faced.

"For instance, women rejected Nalinaibi Health Centre II because they say its security keeper is a man," Mirembe said. "Midwives leave by 6 pm so if a mother is in labour at night, she can't go there because there is no one to attend to her. Mothers do not want to go to the alternative Nabitambala Health Centre III because it has no electricity!"

Although most TBAs were trained and given basics such as gloves and encouraged to refer complicated cases, some of them delay to refer, putting both mothers and baby's lives at risk. Now with the risks of HIV transmission from mother-to-child the TBAs need to learn to refer even more, Mirembe said.

Mama Nsiima notes that despite the experience she had in supporting mothers to deliver, those living with HIV never want to disclose their HIV status even at a time of delivery.

"Most of them never want to go back to hospitals after testing positive and yet they still don't disclose to me. So I decided that women, who come here without antenatal attendance books, do not get my services," she says.

She says she advises every woman who is HIV positive to deliver from a health facility. However, many often lie and she has not yet figured how to manage as she cannot test them.

"I tell them I don't have the technology of preventing transmission of HIV to the baby. I show them the benefits of delivering from a health facility especially when they are at risk of infecting their babies. But they still lie," she notes.

Maama Nsiima confesses that she has lost two babies and three mothers since she began. When death occurs, the TBAs are scorned as if health centres don't lose more mothers, she says.

WHO recommends one midwife for every 175 pregnant women but this standard is far from being achieved in Uganda, where 1.5 million women give birth every year. There are approximately 15,000 well-trained midwives to assist in the childbirth process.

Society still respects TBAs for their social support, success history and their indigenous cultural knowledge, usually acquired through apprenticeship to other TBAs. Yet WHO statistics show that throughout the developing world, a big number of mothers and babies who die are those who prefer TBAs.



Mama Nsiima helping her client, Naigaga

Yet mothers still go there, some due to accessibility, others affordability and others such problems at health centres like customer care, lack of drugs and crowding.

Mirembe says however that the district has embarked on sensitizing the mothers to deliver at a health facility.

"By the way, we ask them to report cases of death of the mother or child during labour to police but in most cases the TBAs and the mothers choose to settle their cases amicably" she notes

Hon. Sarah Opendi, the State Minister for Health, notes that despite the challenges in the country's health system, TBAs should not be tolerated.

"We know that most mothers shun public health facilities because the health workers are rude. But should a mother risk her baby's life and her own life because of that? I think we may be compelled to come up with a legislation to punish all the TBAs because even with the ban, they still continue to operate," Opendi says

However, according to Robina Kaitiritimbi, the Executive Director of Uganda National Health Consumer's Organisation –UNHCO, even the law will not work if the health systems are not strengthened.

"Our health systems must improve its quality of facilities, personnel, equipment and medicine made accessible to all women. Comprehensive sexuality education and services for young people must also be made available for them to appreciate the need to go to health facilities," she notes

Dr Aggrey Mukose, a lecturer at School of Public Health, says Makerere University is conducting a survey on TBAs in the country and will produce the findings in October 2017.

"We have already secured funding from support organisations. We want to establish, how many of them are they in the country, where are they are most concentrated and what are the factors that drive mothers to them?"



HOME OF POLICY: The Parliament of the Republic of Uganda

Good policies but dismal performance

By Evelyn Lirri

Over the years, Uganda has put in place several policies and strategies to deliver reproductive health services and programmes to the population. The Second National Healthy Policy (2010/20), which focuses broadly on health promotion, disease prevention, early diagnosis and treatment, is one of the key reference documents that can help Uganda deliver better on maternal and newborn health indicators.

The Health Sector Strategic Plans (HSSP) I, II and III, are a set of five-year plans that have been in place since 2000 and have also been key in driving this process. The HSSP II and III outline recommendations for provision of services such as routine antenatal care, increased access to family planning services, skilled attendance at birth, provision of prevention of mother to child transmission (PMTCT) services, immunization and encouraging breastfeeding.

The HSSP II continuum of care package also includes targets for reducing the proportion of babies with low birth weight and those with septicaemia (blood poison-

ing, especially that caused by bacteria) —some of the key factors that contribute to newborn death.

How about adherence?

But even with these policies and strategies in place, improving maternal and newborn health remains a major challenge in Uganda.

Prof. Peter Waiswa, from the Makerere University School of Public Health, says Uganda already has enough policies and strategies to address maternal and newborn health issues but it is their implementation that falls short.

“Many of the policies have not translated into action to support interventions on reducing maternal and newborn deaths,” Waiswa, who also heads the Centre of Excellence for Maternal and Newborn Research, said.

For instance, the government outlawed traditional birth attendants to promote facility based births and ensured that there is a health centre within every 5km radius.

But, according to the Uganda Demographic and Health Survey (UDHS) 2011, only 58% of women deliver in a health facility.

Postnatal care coverage also remains very low at 33%.

Waiswa attributes this low uptake to the poor quality services at these facilities, a problem largely acknowledged by policy makers.

Prof. Anthony Mbonye, the acting director general health services, notes that 30 to 40 per cent of all infant deaths in Uganda result from poor care during pregnancy and delivery.

“We shouldn’t just be telling women to go and deliver in a health facilities. They should be able to find high quality services when they go to these facilities. Women should be able to get access to services such as emergency obstetric care when they need it,” Waiswa said.

He noted that high quality maternal care can be achieved if every birth is attended to by a skilled health worker.

However, in Uganda, in spite of the policy, staffing remains a problem. The World Health Organisation (WHO) recommends one skilled birth attendant for every 175 pregnant women. But, in Uganda, according to statistics from the Ministry of Health, there is one midwife for every 7,000 births!

The United Nations Population Fund says Uganda has a shortage of 2,000 midwives.

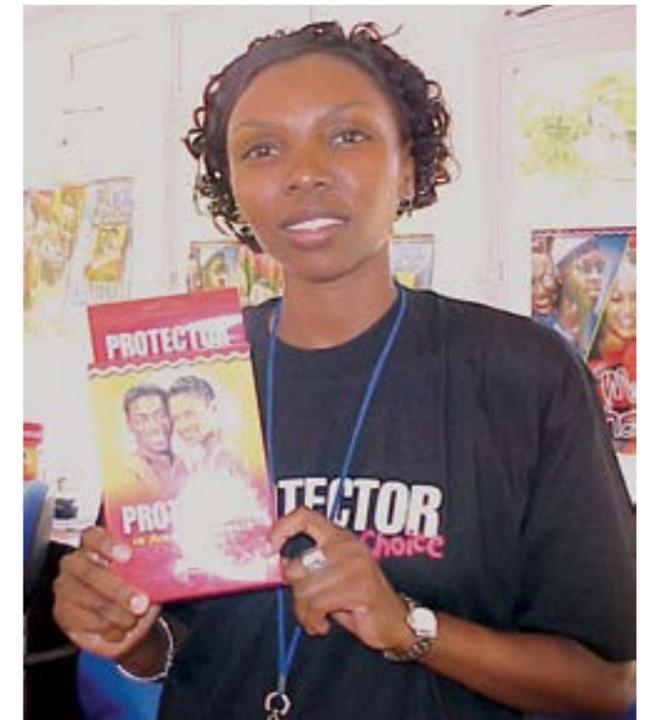
Skilled attendance is important even for mothers without prior history of complications because 15% of all pregnancies end up with life threatening complications, some of which cannot be detected during antenatal care.

Similarly, the policy recommends four antenatal visits to the health facility during pregnancy to prevent maternal and newborn deaths through early detection of potential risks and early management. However, Waiswa says that of all the women who attend antenatal during the course of their pregnancy, only 48 per cent pay all the four visits.

Family planning

The unmet need for family planning remains high at 34% for married women between the ages 15 to 49, according to the UDHS 2011. This gap, according health advocates like Denis Kibira, who heads the Coalition for Health Promotion and Social Development (HEPS), is because of limited availability of contraceptive choices that the government offers.

“Methods such as the long term and permanent remain



FAMILY PLANNING: Lots of unmet needs

unavailable,” he said.

Frequent stock outs of reproductive health commodities have also limited the choice of contraceptive method women will use.

Funding for reproductive health commodities may have significantly increased from \$2.4 million in the 2020/11 to \$6.5million in 2014/15, but with a growing population of young people, the demand for services will continue to be high.

“Family planning therefore needs to be prioritized in budgeting and programming to improve access to services and commodities,” said Kibira.

Dr Charles Kiggundu, a senior obstetrician gynaecologist at Mulago National Referral Hospital also explains that investing in family planning averts unwanted pregnancies and therefore reducing the incidence of unsafe abortions.

“Because of unwanted pregnancies, an estimated 300,000 abortions are carried out in Uganda annually,” he says. “Because most of them are unsafe, they are contributing 26% of all maternal related deaths in the country.”

The problem is exacerbated by the restrictive laws against abortion in Uganda, which make it difficult for women and girls to seek safe services from health facilities. Uganda’s constitution permits abortion only if it is aimed at preserving a woman’s life, her mental and physical health, or when the pregnancy is as a result of



USE: Government policy to increase the number of girls in school and reduce early marriages

incest, defilement or rape. But the tedious process of proving these circumstances discourages many women from seeking legal abortion services, opting instead for unsafe procedures.

“Because of the law, we cannot talk about safe services. Even health workers are not willing to offer post abortion care because of fear of prosecution,” says Dr Kig-gundu.

Uganda has also performed poorly when it comes to addressing the high number of teenage pregnancies, which consequently has an impact on maternal and newborn health outcomes.

Adolescents

The country’s teenage pregnancy rate is considered one of the highest in Africa - at 25 percent. Yet the National Adolescent Health Policy (2000), supports adolescent sexual and reproductive health services. But poor implementation has led to many young people being left out of such services and crucial reproductive health education.

The introduction of free primary education in 1997 was, in part, meant to increase enrolment of girls in school, but also delay marriage, which could consequently reduce early pregnancies and marriage. However, the programme continues to be frustrated by a high dropout rate, especially among girls. This in turn leads to a cycle of teenage pregnancies.

To implement these policies, Waiswa says, more money needs to be injected into the health sector. Uganda signed the Abuja Declaration in 2005, in which African leaders agreed to spend at least 15 percent of their na-

tional budgets on the health sector. The government hasn’t achieved that.

However, Mbonye says Government is already spending a substantial amount of its budget on the health sector. And this signifies the government’s commitment to improving the health of its citizens. He argues that much of the spending in the health sector has gone towards improving service delivery, including recruiting key health workers such as midwives.

Death and birth audits

Mbonye says birth and death audits are also being spearheaded across all health facilities to help government understand the key factors that contribute to the death of mothers and babies.

What Uganda lacks is not policy but a functioning health sector that ensures high quality care, motivated staff, functioning referral system and increase in health budget. Corruption also needs to be curbed to ensure value for money performance. Efforts need to now be focused on implementation.

According to a study by Grace Bantebya Kyomuhendo, Uganda’s good policies have not yielded an increase in utilisation of health services by women or a reduction in the maternal deaths. In her study, *Low Use of Rural Maternity Services in Uganda*, Kyomuhendo revealed that many women still adherence to traditional birthing practices and for some, health centres and hospitals, are considered a last resort. Lack of skilled hospitable staff, laboratory equipment, drugs, emergency care, ambulances etc, must be given greater attention than is currently given, he suggested.



TOWARDS 2030: Government promises better results.

Reducing deaths by 2030

By John Semakula

Today, according to the Uganda Demographic Health Survey, for every 1000 babies born every year, 54 die before celebrating their first birthday and 90 before their fifth birthday. For every 100,000 mothers, 438 die during or as a result of childbirth.

While those figures represent some improvement, health experts say these figures have improved. 167 babies used to die in 1991. And in 1995, mothers dying used to be 505. During the time of the Millennium Development Goals (MDGs), the target was to reduce the deaths to 131 per 100,000. Uganda didn’t meet the target.

Experts attributed this to a dysfunctional health system, poor health services, poor funding, poor staffing levels and motivation as well as structural problems in society.

The goals

Today, we are in the era of Sustainable Development Goals (SDGs), which sets 2030 as the year by which, all countries are required to end preventable deaths of newborns and children under 5 years of age. SDG 3 calls on all countries to reduce the deaths of babies to as low as 12 per 1,000 live births and the deaths of under-5 children to as low as 25 per 1,000 live births.

Within Goal 3 is a task to ensure health lives and promoting the wellbeing for all at all ages. It also includes eradicating HIV/AIDS, malaria and immunisable diseases, some of which are among the top killers of newborns and their mothers. Countries are also expected to increase finance to the health sector.

Uganda has set up a National Newborn Steering Committee, to facilitate reduction of infant mortality with particular focus on integration and coordination of in-

terventions on newborns in the country. According to the Uganda Demographic and Health Survey of 2011, the probability of a child dying within the first month of life stands at 27 babies per every 1,000 live births.

Push factors

Dr. Amos Odiit, Senior paediatric consultant, Naguru Hospital, says baby deaths will remain high for as long as we have a high number of teenage mothers.

“Babies of teenage mothers are more likely to die before or immediately after birth than older mothers. Most teenage mothers don’t know how to look after babies, don’t come to hospital or don’t come in time. Children are very vulnerable in womb and immediately after birth.” he says.

Another reason why we lose many babies, Dr Odiit says, is because we don’t focus on prevention.

“There are still a lot of malaria infections. Not long ago only 10 per cent our population slept under mosquito nets. When rain comes, you expect malaria and diarrhoea cases to rise because of poor hygiene. Many people don’t have adequate food. The problem is beyond the health ministry and cuts across all sectors of governance.”

Dr Odiit said 65 percent of deaths of children are due to malnutrition. When children are malnourished, they are prone to infections, can’t fight infection and develop growth complications.

However, Dr Odiit is optimistic that Uganda can overhaul its deficit if we improve a number of things.

“First of all, improve food security. Secondly, innovate

strategies to delay teenage pregnancies. Then, support the health sector financially, and revamp the health system. For example, the improving referral system and staffing levels and motivation are important steps we must take. Mothers die without going to health centres. Even when they go, many health centres with just three or four health workers expected to serve over 10,000 people! We need to ensure that the ratio of health workers matches that of the population,” he said.

World Health Organisation (WHO) recommends one doctor to every 1,000 people as the ideal.

Another Senior Paediatrician Consultant, Dr. Sabrina Kitaka, expressed hope that Uganda will achieve the SDG 3 with the help of WHO.

“WHO recommended home visits by a skilled health worker immediately after birth to increase survival rates,” she said.

Dr. Anthony Mbonye, the Acting Director General of Health Service at the Ministry of Health, said the country is doing very well in controlling the deaths.

“Government has constructed Health Centre IVs in almost every Sub County to extend antenatal care and services to expectant mothers,” he says

A Health Centre IV is a mini hospital. It has wards for women and children, doctors and senior medical officers, theatre for operations.

Government optimistic

Dr Mbonye said the Ministry of Health is currently collecting data for Uganda’s Demographic and Health Survey 2016. The comprehensive report will be released in January 2017.

He said, preliminary indicators gathered from health unit across the country show tremendous drop in baby deaths.

“Through routine health management information, we have seen a huge drop in mortality at all age groups. This is general trend that we have been able to track,” he said.

Asked about chances of hitting the SDG target of reducing baby deaths to 12 per 1,000 live births by 2030, Dr Mbonye said Uganda was on track.

“We are one of the few countries that managed to hit the target of reducing child mortality and the track goal number six of reducing maternal mortality,” he said. “70 per cent of our health centres are staffed with skilled health personnel. Our people now live on average only 3km away from health units – it used to be 5km. This has increased hospital deliveries for expectant mothers from 40 per cent to 60 per cent,” he said.

The Permanent Secretary of Ministry of Health, Dr. Asuman Lukwago also noted that there was hope that the country will achieve SDG 3.

“But leaders in the health sector and the country should be conscious about resources allocated to health matters – especially training and retaining staff,” he said. “Health workers should also be given freedom to be in-

novative. The health sector thrives on two major things: the attitude of the society and ability of the health workers to be innovative,” Dr Lukwago said.

HIV/AIDS

Dr Mbonye said that Uganda is doing extremely well on the side of eradicating HIV/AIDS. AIDS is among the deadly causes of death of new born babies and their mothers.

“We have registered over 80 per cent viral suppression, 60 per cent of Ugandans with HIV are on ARVs and 90 per cent know their HIV status! That is a big success story!” Dr Mbonye said.

Dr Mbonye referred to the Option B+ to eliminate mother to child HIV infection, where Uganda has achieved 86 per cent success in roll out. This is where all mothers are tested for HIV during antenatal visits, those found positive are given ARVs, together with their partners for life. Their pregnancies are monitored, they delivered by caesarean and the babies are given treatment up to six weeks.

According to Dr. Mbonye, Uganda is about to eliminate mother to child transmission of HIV and has already conquered immunisable diseases like Polio, measles and Tuberculosis with 90 per cent success!

Implementers speak out

However, doctors in the trenches doubt Uganda can achieve the targets, especially if it keeps doing things the way it does.

Dr. Bayigga Micheal Lulume, the former shadow minister for health in the 9th Parliament, says building beautiful health centre buildings alone cannot solve the problem of mothers and babies dying.

“You need much more – high-quality motivated staff, more equipment, and drugs,” he said. “What level of motivation and emolument is there for our health workers?”

He adds that government heavily relies on foreign partners to run its key programs in the health but you cannot guarantee resources you don’t control neither can you set priorities concerning resources you can’t control.

Prof. Ben Twinomugisha, a researcher in the health sector, says the current health budget needs to at least be doubled.

“We need about 15 per cent as was agreed upon by the Abuja Declaration. Currently, we are hovering at between 8 per cent and 9 per cent yet most of the money goes on workshops and conferences. We need to segregate a huge chunk of the budget to maternal health because it is crucial,” he said.

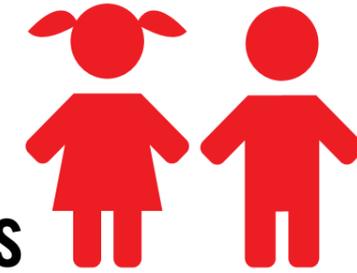
A law professor at Makerere University, Twinomugisha says critical things in child health like nutrition information, breastfeeding and primary health care could make a very big difference.

“I believe something is being done. I know we may not get there, but we can improve. Any step should be applauded,” he says.



WE'RE CAMPAIGNING FOR:

Children living in remote areas



Attendance rate for children in pre-primary education is at 5% in West Nile region compared to 62% in the capital city of Kampala.



Deprivation rates are higher (58%) in rural areas than in urban areas (31%).

So we are taking action...

to pressure the government to review the health spending and ensure that resources are allocated equally.

to pressure the government to implement a cohesive child protection policy specifically in remote regions.

UGANDA



Over 80% of doctors and 60% of nurses in hospitals serve the urban population



58% of adolescent girls in Uganda have experienced some form of physical or sexual violence.

IN EVERY COUNTRY, WE'RE CALLING FOR THESE GUARANTEES FOR EVERY LAST CHILD:

FAIR FINANCE

Create global rules and national systems that enable money to be raised and spent in ways that get every child the essential services they need to survive, learn and be protected.

EQUAL TREATMENT

Challenge and change laws and behaviours that discriminate against children, in ways that stop them from surviving, learning and being protected.

ACCOUNTABILITY TO CHILDREN

Give excluded children and their communities a voice in the decisions that affect them, and ensure that every last child is registered and counted.



Save the Children

THE
Health Digest

Plot 156-158 Mutesa II Road, Ntinda
P. O. Box 4883 Kampala -UGANDA
Tel: 256 704 292188

healthdigestUG@gmail.com Website: www.hejnu.ug