Maternity Services in Hoima, Uganda

A report from the visiting team from Basingstoke and North Hampshire Hospitals NHS Foundation Trust

October 3rd -13th 2008

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Introduction

This report was written at the request of Dr Emanuel Moro, Medical Superintendent, Hoima Regional Referral Hospital, Hoima, Uganda. The author is Mr Robert Bates, Consultant Obstetrician and Gynaecologist, Basingstoke and North Hampshire Hospitals NHS Trust. This report follows from a visit to Uganda by a group of five doctors and four midwives from Basingstoke and Reading between October 3rd and 13th 2008. I am very grateful to Dr Jo Meikle, Dr Greg Boden, Miss Jemma Horsfield and Miss Louise Emmett whose contributions to this report are identified in the text.

The Group visited Uganda at the invitation of Dr Emanuel Moro and as a further development of the Basingstoke Hoima Link, first established in 2007. In May 2007 Mrs Jill Pellet, Senior Manager and Mr Nigel Rossiter, Consultant Orthopaedic Surgeon visited Hoima to explore the possibility of our Trust working with Hoima Hospital and establishing a link between our two units. This was followed by a very successful return visit to Basingstoke by Dr Emanuel Moro, Sister Florence Achung, Senior Principal Nursing Officer and Mr Louis Ngobi, Senior Administrator in February 2008.

At our meeting with the Ugandan team in Febr

The National Maternity Conference was kindly sponsored by the Ugandan Ministry of Health and several members of the Ministry together with the senior member of the Ministry team, Dr Oballa, were in attendance. Members of the ministry team asked if I would forward a copy of this report to them and I am delighted to do so.

Scope of this report

This report sets out to review the findings of our small team of doctors and midwives who visited Uganda for a limited amount of time. Therefore it does not set out to act as a comprehensive review of all aspects of the maternity service in Hoima, less still in Uganda as a whole. However, concerns about the high maternal and perinatal mortality rates in developing countries are well known and background information for Uganda is summarised in the following section.

The report describes the experience of the visitors after working with local staff in Hoima from four separate perspectives i.e. obstetric, anaesthetic, Paediatric and Midwifery. Our experience and understanding of the Ugandan healthcare system was broadened after having the opportunity to visit Mulago Hospital and after working and interacting with our Ugandan colleagues at the National Maternity Conference.

Finally the report sets forth two sets of recommendations. The first are general recommendations which the Local and National Healthcare systems will hopefully find helpful. The second set of recommendations are specific measures which the team from Basingstoke feel they could help to implement with the cooperation of local members of staff to ensure sustainable improvements to maternal and neonatal care.

Introduction – Maternal Health in Uganda

Improving the health of women during pregnancy and childbirth is an international priority, as well as a local one wi
Development Goals is to reduce maternal mortality globally by three-quarters by the year 2015, with much of this reduction expected across low income countries (United Nations, 2000). The Ugandan Ministry of Health has set its own goal of reducing maternal mortality by 70% (Uganda Ministry of Finance and Economic Planning & Macro International Inc., 1996), in line with this global effort.

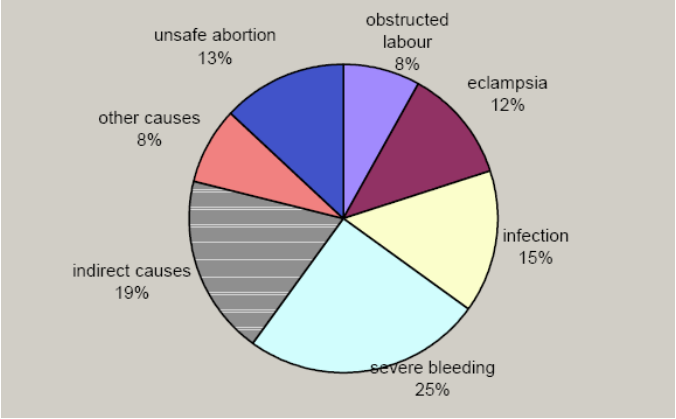
The Maternal Mortality Ratio (MMR) in Uganda was estimated in the 2000 -2001 Demographic and Health Survey (DHS) at 505 maternal deaths per 100,000 live births (Uganda Bureau of Statistics, 2001). It was reported at the National Maternity Conference that the Maternal Mortality rate had decreased to 435 per 100,000 pregnancies. There is some doubt as to whether this change is statistically significant and it remains unacceptably high compared to a rate of 10 per 100,000 in Northern Europe.

The prevailing high rates of fertility (6.7 births per woman) in an environment of poor access to quality maternal and neonatal care have continued to expose Ugandan

mothers and infants to a high risk of death from pregnancy related causes (Uganda Ministry of Health & WHO, 1996), with an estimated 1 woman in 10 dying from maternal causes in Uganda (the lifetime risk) (Safe Motherhood, 2002).

The main causes of maternal death have been estimated as follows:

Causes of Maternal Death in Uganda



Source: Sexual and Reproductive Health Minimum package in Uganda 2000 (adapted from safe motherhood needs assessment 1995-6) (Uganda Ministry of Health, 2000)

Note – Estimates of the impact of abortion vary considerably by source

The primary means advocated internationally to achieve a reduction in maternal mortality is through increasing the number of women who deliver with a skilled birth attendant i.e. a doctor or nurse/midwife. Only 39% of Ugandan women deliver with a skilled attendant, with this rate remaining fairly constant since the late 1980s. This rate is slightly below the African average of 42%.

Although we are not in a position to influence directly the issues around women delivering without a skilled attendant, the visiting team became quite convinced that significant improvements in maternal and neonatal mortality could be achieved by improved care by skilled birth attendants. Further, an improvement in care delivered

about place of birth and attendant.

Obstetric Provision - Robert Bates, Consultant Obstetrician

Hoima Hospital

The team arrived in Hoima early in the afternoon of the 3rd of October. The team were greeted and made to feel very welcome by Dr Emannual Moro and Sr. Florence Acheng who were both part of the team that visited Basingstoke last

January. We were then given a guided tour of the Hoima Hospital site and in particular the Maternity and Paediatric Units as well as the operating theatres.

Our first impression of the Hoima Maternity service was that the facilities were very basic and the level of care provided was poor. The maternity ward was overcrowded with no space between beds and a number of patients were on mattresses on the floor. The Hospitals statistics for 2007/2008 (Annual Report for Regional Referral hospitals) shows a bed occupancy rate of 166%.

The delivery rooms were small and there were two beds in each with no curtains around or between them. There were two women in labour in some rooms with no possibility of privacy and at least one woman was in labour in the corridor, lying on the floor.

Overall standards of hygiene and cleanliness were poor. Sharps boxes provided for used needles and syringes were full to overflowing and heavily contaminated with old blood on the outside. Although water was available for hand washing on the first

soap was available in the delivery rooms. There were no indoor toilet facilities and the women had to go outside to a nearby clump of trees.

Although most staff are aware of the obstetric partogram and many claimed to use it, we found no evidence of its use in Hoima. Maternal monitoring is inconsistent and fetal monitoring takes place hardly at all. We found a single Pinnard fetal stethoscope but there were no facilities at all for electronic fetal monitoring. There appeared to be little or no concern about fetal wellbeing.

Medical and surgical equipment were also severely lacking. There was a single ventouse device which was dirty and poorly maintained and stored in an old briefcase. The annual report shows that there were no ventouse deliveries in 2007/08; the only method of operative delivery being caesarean section.

There is a single operating theatre some distance from the Labour Ward. Transfer to theatre requires a journey on a trolley out in the open between buildings. There is no proper path and women in pain with obstructed labour are wheeled on a trolley over a rough dirt path. The single operating theatre is used by all surgical disciplines. The surgical equipment in theatre was wholly inadequate. The scissors were blunt, the forceps were old and worn out, there were no large swabs and very few small swabs available.

There are no recovery facilities and post operative patients wait in a corridor for transfer back to the ward. There is no HDU at present though this is one of the

beds

and no equipment at the time of writing

have a higher than average maternal mortality rate as it is a regional referral centre and as such has an above average high risk caseload.

Obstetric and Midwifery staff

By UK standards there seemed to be a lack of kindness and compassion on the part of the medical and midwifery staff and there was little attention paid to preservation of dignity. To some extent this may be as a result of server understaffing and the staff in the Unit being completely overwhelmed. We were told that in all there are eight midwives on the staff whilst in a comparable unit in the UK there would be 80-100. This often results in a single midwife having to look after six or more women in labour at any one time.

There did not appear to be enough medical support for obstetrics or any senior back up. The only consultant who specialises in obstetrics is usually rostered on call for Hoima 11 months of the year but at the time of our visit was away on their holiday for the month. On the second day of our visit when a woman required a difficult caesarean section the doctor on call for delivery suite had only qualified as a doctor three months previously. He was a very bright and enthusiastic young doctor but it would be wholly inappropriate for a doctor at his level to carry out such a procedure unsupervised.

Obstetric Case Experience

Our team were involved in two obstetric emergencies with the blessing of Dr Moro. The first was a 36 year-old woman who was in labour at term in her eighth pregnancy. Her labour had been obstructed for more than 24 hours and this could only be described as neglect. I carried out the caesarean section assisted by one of

occipital posterior position and the bladder was very oedematous. There were no large packs available. The instruments were old and in poor condition. This was an extremely difficult procedure and made worse by the lack of adequate equipment. This woman is at high risk of fistula formation due to bladder necrosis.

The anaesthetic was given by a local anaesthetic technician assisted by Jo Meikle, one of the UK anaesthetists. This is described separately (see below).

The baby came out very flat with a heart rate of about 40 beats per minute and an Apgar score of 2. The baby was resuscitated by Gail Nance-Kivell, one of our midwives. It seemed that there was no routine provision for a midwife to look after the baby after delivery and the anaesthetist would be expected to carry out resuscitation as well as look after the anaesthetised woman. Further, the baby had to be resuscitated by mouth to mouth inflation as the available neo-natal mask and ambu-bag did not fit together. Fortunately the baby survived.

There was a complete lack of recovery ward facilities and after surgery the patient was left in the theatre corridor with no monitoring, no oxygen and no recovery nurse

looking after her. Remarkably both mother and baby survived and were discharged home four days later.

The second case was a 19 year-old woman who was unconscious after several eclamptic fits during the past 24 hours. I was called on my mobile telephone to ask if I could review the patient as there was difficulty in arranging medical review. The woman was assessed by Dr Meikle and me. She was deeply unconscious and responsive to deep pain only. An ultrasound scan showed that the baby had died in utero. On pelvic examination the cervix was fully dilated so I delivered the baby using an old-fashioned ventouse device that had clearly not been maintained or cleaned in a very long time.

The local staff explained that their management of this case would have been to have performed a Caesarean section for delivery of the dead fetus. This would have been an entirely inappropriate and extremely hazardous procedure, which may well have resulted in the death of the woman.

Miraculously, the patient was conscious by the following day and at 48 hours was able to walk. Further progress reports suggest that she has been able to leave hospital and she continues to recover.

Azure Maternity Unit in Hoima

The team also visited the Azure Maternity Unit which was set up by Duncan and Helen Sherlock with charitable funding from the UK. The conditions in the Azure Maternity Unit were in dramatic contrast to those in Hoima Hospital. The beds were all numbered and a reasonable distance apart. There was fresh linen on the beds and the post-natal women were all dressed in brightly coloured clothes and the whole atmosphere was pleasant and cheerful. The number of deliveries has rapidly increased in the Azure Maternity Unit. This is purely on the basis of word of mouth recommendation
women will seek out skilled birth attendants if the environment is seen as safe and comfortable and the staff are compassionate.

Masindi and Kibogu

We also visited two other hospitals in the Hoima region; Masindi and Kibogu. Although we did not have the opportunity to observe practice in these units, we felt they had a more pleasant and friendly atmosphere than Hoima and certainly better than the maternity unit in Mulago (see below). In general, we found that the smaller local units appeared to take better care of their patients and treat them with more dignity and respect.

The organisation of the hospital site was evident at Masindi. They recognised that women and their families who often accompany them into hospital, all require access to facilities for washing and cooking in order to fulfil basic human needs. There were dedicated areas for these purposes as well as units built for toilets and bathing.

At the time we visited Kibogu the unit had run out of an anaesthetic agent known as suxamethonium. As a result, it was sending all its patients that required an operation

to Hoima or Kampala while it waited for a supply of suxamethonium to arrive from the central drug ordering service.

Hoima had suxamethonium in stock, but it seemed illogical to send patients to Hoima rather than send a supply on loan. This is an inexpensive drug which could have been sent on a motor cycle. In addition, to compound the difficulty, the same weekend that Kibogu referred their patients to Hoima, Hoima had no anaesthetist for the majority of the weekend as they did not arrive for duty.

Obstetric provision in Mulago

The team visited Mulago Hospital on October 6th prior to the national Maternity Conference at the Equatoria Hotel the following day. Mulago Hospital in Kampala is the main National Referral Centre in Uganda. Conditions in the Maternity Unit at Mulago came as a real shock to us. Mulago delivers around 80 women every day but there are only 8 delivery rooms. To put this in perspective, the delivery rate at Mulago is around 30,000 per year yet it has the same number of delivery rooms as our Unit in Basingstoke, which delivers around 3000 per year i.e. one tenth the figure for Mulago.

The corridor in the Mulago Labour Ward was occupied by at least 20 women in strong labour lying around on the floor in various states of undress waiting to go into one of the delivery rooms. We witnessed five white coated medical students each trying to deliver a woman on a couch with absolutely no partition between the couches or any attempt at privacy. We also saw an incident where a dead baby wrapped up in a towel was left on a trolley about 8 feet away from a young woman who was awaiting a forceps delivery.

As elsewhere in Uganda, the main problem in Mulago is that they are chronically understaffed. The midwifery sister we spoke to said she is supposed to work 8 hours a day, 5 days a week but in practice she tends to work 12 hours a day and also has to come in on some of her days off.

Anaesthesia provision - Dr Jo Meikle, Consultant Anaesthetist

Anaesthetic Staffing

There did not appear to be adequate anaesthetic cover for Hoima Hospital. We were informed of an emergency case where the hospital had been unable to find an anaesthetist to attend. It was unclear if this was because an individual had refused to come in when they should have done or if there are not enough anaesthetic officers to provide round the clock cover. The anaesthetic officers did not receive much if any CME or support from medically trained anaesthetists. This makes it difficult for any of them to make changes to improve practice. The anaesthetic officer I worked with was thorough and was doing his best in difficult circumstances. He had a sound knowledge base but was severely limited by the lack of drugs and equipment.

Anaesthetic Technique

I was surprised that so many of the patients having caesarean sections in Hoima had general anaesthesia in preference to regional anaesthesia, which I would have thought was not only safer, but provided better analgesia post-op. The anaesthetic officer I asked about this said that he found regional anaesthesia difficult as he was also required to resuscitate the baby on delivery. He found that when he was using regional techniques the women became hypotensive (a common side effect of regional anaesthesia), and that he could not manage this and be resuscitating the baby. He found it easier to give a general anaesthetic. Whilst I understood his problems, this did seem to expose women to greater than necessary risks, especially considering the lack of adequate monitoring.

Equipment and Drugs

The anaesthetic machine in Hoima is an old very simple EMO machine, which has served its purpose for many years delivering ether. They had been given a complex machine which has never worked, illustrating that there is little point in donating out of date equipment which cannot be maintained. There was very little monitoring in theatre. There was an oxygen saturation monitor, which the anaesthetic officer thought did not work very well as it did not pick up saturations in patients who were hypotensive. In fact, this is true of all oxygen saturation probes and perhaps indicates the condition of most of the patients during anaesthesia. We tactfully discussed this with the anaesthetic officer.

There was an old manual sphygmomanometer, which again the anaesthetic officer had to be prompted to use. There was no means of monitoring the amount of anaesthetic delivered to the patient, ECG or end tidal carbon dioxide. My overall impression is that after induction for a caesarean section the anaesthetic officer sits back and hopes for the best!

There was a very limited range of drugs in theatre. I saw no analgesic drugs at all, and only a few vials of the vital drugs like thiopentone and suxamethonium. I understand that there is a problem with stock disappearing from the hospital, but not supplying in the first place does not seem a sensible solution to this problem.

We had a supply of IV fluids available, but were informed that availability is very variable. Blood was sometimes available, but on a limited basis. It was transported over from Kampala, which would have taken at least 2-3 hours. It seems likely that some people will be operated upon with very limited fluids available and no blood.

Recovery and post op monitoring

There was no recovery area and patients were not monitored as they recovered from their operation. When we went to theatre for a Caesarean section, the previous patient was on a trolley, unmonitored and without oxygen in the theatre corridor. She had had a Caesarean section a few days previously and had come back to theatre with peritonitis and had a laparotomy. In the UK a patient with this kind of complication would be managed in Critical Care, and the contrast was striking. In

Hoima she was transferred straight back to the ward, where again there was little monitoring

At the conference, after my lecture on obstetric haemorrhage, one of the delegates asked why sometimes when they have treated haemorrhage the patient later deteriorates and dies. It seemed very obvious that better post-op monitoring would pick up some of these patients earlier in this process and allow time for appropriate management. There seemed a real lack in post operative care, so that complications of childbirth which would be detected and managed appropriately in the UK actually led to maternal mortality which in many cases would be preventable.

Neonatal Resuscitation - Dr Greg Boden Consultant Neonatologist

The resuscitation station at the National Maternity Conference proved that all present were very keen to learn resuscitation skills and all 147 delegates spent time at the tables practicing their skills. It was noticeable on the second day that they had already changed their practice in the way they approached and practiced on the manikins.

Because of the difficulties in the obstetric service, infants are often expected to be in poor condition at birth. From discussions with Doctors and Midwives at the resuscitation station at the conference, it was evident that there is not only a lack of staff available for infant resuscitation but there is no preparation made for a potentially asphyxiated infant. Basic equipment is lacking and often this is not expensive and is reusable. All were unfamiliar with international guidelines on newborn resuscitation and care and there is no system in place for training professionals in newborn resuscitation.

I believe a huge difference could be made just by providing basic equipment and training and then most importantly, training Ugandans to be instructors and provide ongoing training locally. Hopefully our sessions proved helpful and have resulted in some debate amongst the delegates, this, as with everything we did at the conference will fade away unless there is further reinforcement of the principles we were teaching and I hope to maintain contact with a number of the delegates we met to keep reminding them, amongst other things, to STOP SUCKING!

Midwifery Miss Jemma Horsfield, Midwife

We had the opportunity to practice as midwives and care for a number of women in labour whilst in Uganda. On our first full day in Hoima, Louise Emmett and I offered to support the midwives on the labour ward. Unfortunately this seemed to signal a break for some of the Ugandan midwives who disappeared from sight, and left us to it.

Each patient had a medical card and most of the women had been seen a few times during the pregnancy. If antenatal screening for HIV had not been carried out this

details were entered in the birth register to be completed at a later date.

The women bring a bundle known as the delivery pack. This consists of some pieces of material for the baby, a roll of cotton which serves the purpose of nappy and sanitary pads but is not good for trying to wash a woman as we discovered! They also bring gloves, a blade for cutting cord and sometimes cord ties. The women also are expected to provide a black plastic sheet to place on the bed to serve as a clean environment.

We saw several women in the early stages of labour with ruptured membranes and felt the management plans for these women were interventionist and confused. A woman in her fourth pregnancy at term had ruptured her membranes and was draining clear liquor. She was not contracting and in the UK we would manage her conservatively. Further examinations at this stage are considered unnecessary and likely to increase the risk of infection. Even though she was not contracting, the midwifery sister was adamant that further vaginal examinations should be carried out though she was unable to explain her rationale for this. There was no attempt at aseptic technique and no plan made for further care. The lady was still there the next day with no further management plan in place.

Basic observations such as blood pressure monitoring were not always possible. for a time the key holder was away from the unit so that important observation could not be performed. We were told that the equipment is locked away because equipment goes missing and may be stolen. There was one Pinnard fetal stethoscope and that was the sum total of the equipment available for fetal monitoring.

There were no sanitary facilities for patients and although there was one toilet on labour ward, we were told this was for staff only and was kept locked. The women passed urine by squatting over a metal dish or drain and there was a strong smell of urine everywhere.

The first stage of labour were managed by allowing women to walk around outside and return at pre arranged times to have vaginal examination and fetal observations. The women appeared to remain fairly mobile however some women were clearly too exhausted to move and certainly no one was eating or drinking although it was very

The management of the second stage of labour was in complete contrast to management of the first stage. Women were placed in the lithotomy position and instructed when to push. However, there was a lack of knowledge about directed and coordinated maternal effort and the effects it might have on fetal heart rate. There was minimal fetal monitoring and little thought given to preparation for the arrival of a baby which may need resuscitation.

Amniotomy was performed routinely and a syntocinon infusion commenced to increase contractions. There was no equipment to regulate infusion rate and we

knowledge about bladder care during or after labour, and poor aseptic technique. A

single catheter was used repeatedly on each woman due to limited supplies. For some reason catheterisation was preferred to allowing the woman off the bed to help her squat over the metal dish - although this in itself would help the second stage of labour.

There was a marked delay in allowing skin to skin contact between mother and baby. The midwives insisted the mother was washed before she could hold the baby because she was dirty. All the babies were automatically suctioned at birth then dried washed and wrapped. There was no support for mother or baby to establish infant feeding.

The management of the third stage of labour was by controlled cord traction. The placenta was not checked to see if it was complete.

National Maternity Conference

Eighty two midwives attended the National Maternity Conference. These midwives were asked to name one thing they would like to change in the antenatal, intrapartum and postpartum periods in order to improve care offered to women. The following is a summary of some of the issues raised

Late referral from TBA's
The number of women admitted in very early stages of labour because they did not wish to make the long journey home
Chronic lack of midwifery staff
Chronic lack of experienced doctors
No equipment
Long delays waiting for emergency LSCS to be performed
The need to reduce the birth rate and complications from illegal abortion
Taking midwifery care into the community to improve accessibility
Teaching on contraceptive issues for school children

Lack of ongoing training with particular reference to

- Antenatal care
- HIV infection
- Management of normal labour
- Shoulder dystocia
- Instrumental delivery
- Management of obstetric emergencies such as PPH
- Puerperal and post abortion sepsis

The UK midwives led small discussion groups on the management of obstetric emergencies such as shoulder dystocia. In my group there was little insight that this was an emergency life threatening situation. Only a few people linked it with maternal complication such as uterine rupture and PPH. Most were aware that the baby would be difficult to resuscitate but no-one said that specific preparation would be made for this eventuality.

When asked about management of shoulder dystocia there was mention of fundal pressure and keep pushing/ pulling which is generally acknowledged to make matters worse as there is a bony impaction. Most were aware of the McRoberts manoeuvre although they did not know it by this name or know the purpose of this manoeuvre as it was usually instigated by a doctor.

At the end of the workshops the delegates were amazed that they had learnt new skills which were relatively easy to remember.

Overview of Midwifery Care: Louise Emmett

In order to provide effective care midwives need to be proactive and work as part of a multi-disciplinary team. This relies on good communication between colleagues to plan the care of women who are at high risk or have complications in pregnancy or childbirth. In Hoima there was an overwhelming impression of a lack coordinated care and a lack of teamwork.

The Midwives seemed to have a very limited understanding of how to monitor or implement treatments in labour. In particular there was a lack of fetal monitoring and palpation of contractions. Whilst some Midwives had some theoretical knowledge this did not translate into clinical practice. Care provision is routine, reactionary and not individualised. We were particularly concerned about the apparent lack of understanding of how to anticipate or recognise obstetric emergencies.

The hardest part to come to terms with was the lack of interaction of the mothers with their babies. Once delivered, they are wrapped and then almost discarded by their side. No plans are made to identify infants potentially at risk of hypoglycaemia, hypothermia or RDS. There was a lack of breastfeeding support and no emphasis on promoting maternal bonding.

Most of the staff worked hard and staffing levels were poor but we did feel that there was a lot of inefficiency and unnecessary activity. Unnecessary in-patient activity adds to t hospital capacity. This comes about primarily because of:

Unnecessary admissions
Lack of management plan results in avoidable complications.
Unnecessary interventions procedures used routinely may not be efficient or effective and may prolong recovery times e.g.

- Episiotomy
- Labour and delivery in supine or lithotomy position
- Repeated vaginal examinations
- Lack of oral hydration
- Division of the umbilical cord prior to delivery of the shoulders

Summary

The facilities for the care of pregnant women in Hoima are lacking in many respects. The hospital buildings are cramped, insanitary and lack even basic provision for privacy. There is an almost complete lack of basic equipment on the delivery suite. In particular there is limited access to sphygmomanometers, only a single ventouse forceps device which is barely serviceable and theatre equipment which is wholly inadequate. The service is grossly understaffed and the staff are in effect victims of abuse by the system they work for. This is reflected in poor and unsympathetic care. There are too few midwives and doctors. The latter are often inexperienced and unsupported.

Midwives, Obstetricians, anaesthetists and paediatricians are all part of a multi-disciplinary team which relies on good communication between colleagues to plan the care of women who are at high risk or have complications in pregnancy or childbirth. In Hoima there was an overwhelming impression of a lack coordinated care and a lack of teamwork. Although staff have some awareness of obstetric emergencies there is no coordinated effort to carry out risk assessment, take precautionary measures or plan for the management of emergency situations which may occur.

The majority of women in Uganda deliver in the care of a traditional birthing attendant. This is perhaps not surprising since many women will have to travel a considerable distance to a maternity unit. However, even if a service is available locally women will be understandably reluctant to come to hospital because they perceive the service as being poor, unsympathetic, degrading and unsafe. The great progress made in the Azure Clinic shows what can be done to persuade women to come to hospital to deliver by providing a safe, clean, caring environment. We believe this is perhaps one of the most important lessons to learn in addressing the issue of encouraging women to seek out a skilled birthing attendant.

General recommendations

The Hoima Hospital site is inadequate to meet the needs of the 3000 women who deliver annually. Expansion of the Antenatal Ward facilities and Labour Ward are required to meet present demand and of course a greater expansion would be required to meet the needs of the 60% of women who deliver with TBAs, should they be persuaded to deliver in Hoima Hospital.

An alternative option would be to expand the service at the Azure Maternity Hospital. This Unit has already established good practice in many areas and is proving very popular with local women. It is possible to envisage an expansion of the Azure site

st practice can be developed and then promulgated throughout the region and beyond. I imagine this would require the agreement and cooperation of the Ugandan Ministry of Health and the Charity which is responsible for running the Azure clinic but I believe it is worthy of consideration.

In the meanwhile, the following could be implemented in Hoima to improve care to women:

Facilities

Build toilet facilities for women in the Antenatal and Labour Wards
Build a walkway between the Labour Ward and Theaatre for transfer of patients requiring caesarean section

Basingstoke – Hoima Link

The nine of us very much enjoyed our time in Uganda. There is considerable enthusiasm in the group for a return visit by us and also new participants. We very much want our visit of October 2008 to be the first of many and the start of a long term partnership in which we will endeavour to help to improve the healthcare provided to the people of Hoima and in particular to pregnant women.

We believe a huge difference could be made just by providing some basic equipment and training and then most importantly, training Ugandans to be instructors and provide ongoing training locally. We would like to have the opportunity to return to Uganda as a small team of Obstetricians, Midwives and anaesthetists to work alongside our Ugandan Colleagues for a week or two. Our aim would be to try and instil good practice and train local staff in areas such as active management, recognition of complications of labour, management of emergencies and neonatal resuscitation. We would also try to identify key local members of staff who we could develop as local trainers so that they can continue to provide ongoing local training after we have left.

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