



Congestion Nurses attend to newborn babies on life support at Kawempe General Hospital. The many babies born daily often outnumber the number of incubators at the hospitals, leading to deaths. PHOTO BY ERIC KIMWANI

The challenge

While health centre IVs are supposed to provide comprehensive emergency obstetric care, most of them cannot, forcing mothers to flood hospitals, writes Lilian Namagembe

At the entrance of Kawempe General Hospital in the wee hours of August 12, a mother attracts the attention of caretakers as she wails uncontrollably.

"My baby is dead," the helpless mother yells to a man who is trying to console her.

Having developed labour pains hours earlier, the mother, who seemed to be in her 30s, had been admitted to Kasangati Health Centre IV in Waiso District, from where she was referred with suspected obstructed labour to Kawempe General Hospital, a subsidiary of Mulago National Referral Hospital.

While health centre IVs (HCIV) are ordinarily planned to provide comprehensive emergency obstetric care, including caesarean sections, blood transfusion and anaesthesia (induced loss of sensation prior to surgery), most of them across the country do not have adequate

Newborn babies in danger as congestion hits govt hospitals

capacity in terms of personnel and supplies.

As a result, general and referral hospitals receive overwhelming numbers of expectant mothers from health centre IVs, which only conduct normal deliveries, and health centre IVs. This puts more pressure on the insufficient beds, health workers and other medical supplies.

Having travelled about 20 kms from Kasangati HCIV the previous day, the mother joins others in a queue at the registration table next to the labour suite at the hospital.

The long wait

They wait for more than 30 minutes before joining another queue where they are examined, making it more than an hour before a mother is attended to at the hospital.

At Kawempe hospital, the situation is not different from many public funded hospitals. The more than 80 mothers delivered of their babies on a daily basis have to compete for the

60 beds in the hospital labour suite, which forces others in early labour to lie on the floor. Worse still, the post-natal ward where mothers are supposed to be referred six hours after normal delivery is only equipped with a mattress where they lie on the floor without beds, which exposes their babies to infections that can lead to death.

When her turn to deliver comes, she does so normally. Mother and baby are both well before the latter is transferred to the neonatal intensive care unit. However, the baby is later pronounced dead.

"This happens all the time. She had better be strong and go bury her baby," one of the passers-by murmurs to a colleague.

Similar scenarios of preventable deaths of newborns are common, especially in the countryside health centres as a result of delays at the overwhelmed referral hospitals.

The administrators at the national and other regional referral

IDEAL DELIVERY STEPS

Step 1. Mother reports to hospital and is examined on arrival.

Examination involves listening to the fetal heart, the position, size of the baby, all of which determine the mode of labour (normal or C-section). The mother should not wait for more than 30 minutes.

Step 2. Emergency cases (in case of C-section) should also last for not more than 30 minutes.

Step 3. Monitoring mother and baby for the first six hours after delivery.

Step 4. The mother is transferred to the postnatal ward to relax and is monitored for 18 hours before she is discharged in case all is normal and is supposed to return after six days and there after, six months.

hospitals have often complained that equipment used in the delivery of babies breaks down fast because of the many expectant mothers who flock the hospitals from the non-functional lower health units.

The situation also explains the infant mortality rate of 27 per 1,000 live births, according to the 2016 Uganda Demographic Health Survey, which falls short of the Health Sector Development Plan target of 16 per 1,000 live births.

Infant mortality rate refers to the number of infant deaths that occur for every 1,000 live births as a key indicator of the state of maternal and newborn health care in a country.

The latest 2016/2017 Annual Health Sector Review report puts infant mortality at 35 per 1,000 deliveries at regional referral hospitals across the country.

The sector report ranks Hoima and Mubende hospitals with the highest child mortality rate at 34 per 1,000 and Jinja General Hospital at 27 per



Worry. "A mother here needs between Shs80,000 and 90,000 to fuel the ambulance in case of a referral to Arua Regional Referral Hospital, about 80 kilometers away. However, in most cases a mother has no money, which leads to delays as they try to look for the money," **GEORGE NGAPARE**, RHINO CAMP HEALTH CENTRE INSPECTOR



Concerns. Expectant mothers wait for antenatal care at Kawempe General Hospital, a subsidiary of Mulago National Hospital, recently.



"Some patients require listening to their fetal hearts every 30 minutes but you have three midwives in the labour ward, and you have 20 mothers, how are you going to monitor them? You can't!"

HARRIET NAKAZZI, A NURSING OFFICER AT MULAGO HOSPITAL

labour and post-delivery.

"Some patients require listening to the fetal hearts every 30 minutes but you have three midwives in the labour ward, and you have 20 mothers; how are you going to monitor them?" Ms Nakazzi says.

She adds: "As you are monitoring a baby, the other one is delivering; she is delivering a baby of a low Apgar score (points for heart rate, breathing, skin colour, tone and baby's reactions) you resuscitate that baby and any time anything can happen."

As a result, some mothers keep away from the physically drained midwives who they accuse of being rude. This has left the traditional birth attendants (TBA) to handle mothers, which exposes mothers and newborns to risks.

Though the TBAs were banned by government in 2010, they continue to utilise grimy bedrooms, sheds and gardens to stealthily deliver mothers, exposing babies to deadly infections as well as delays in case of complications.

This has left the majority of newborns whose mothers cannot afford the costly but efficient services in privately owned hospitals vulnerable to preventable death as mothers search for the easiest way out.

1,000 hospital deliveries.

Dr Edward Nkurunziza, the Jinja Hospital director, explains that many mothers usually delay to visit health facilities, a scenario that lowers babies' survival chances. "This makes many babies to compete for the few available incubators. We usually improvise with the Kangaroo method [where a mother holds a baby on her bare chest] to warm other babies," Dr Nkurunziza says.

However, the Kangaroo method is not as effective as the incubator in limiting the amount of dust and allergens that a baby is exposed to, as well as regulating the temperature.

The high congestion and inadequate resources in regional referral hospitals and lower health centres in turn, expose newborns to the country's leading causes of child mortality, including anaemia at 13.6 per cent, pneumonia 13.1 per cent and neonatal sepsis 7.3 per cent.

Constraints

Dr Alfred Anyonga, the in-charge of Princess Diana Memorial Health Centre IV in Soroti, which recorded the highest newborn death rate at 16.3 per cent in Financial Year 2015/2016, says lack of anaesthetic officers is the reason why they are incapacitated to carry out C-sections.

An anaesthetic officer conducts anaesthesia, a state of temporary loss of sensation to a mother as a way of controlling pain before a caesarean section is conducted.

"It (the lack of an anaesthetic officer) pushes us to immediate referral service," Dr Anyonga says.

Although not more than 15,000 people are supposed to be served by a health centre IV in a particular county, most of them, especially

those neighbouring border points and refugee camps, surpass the recommended numbers.

At Rhino Camp Health Centre IV, which neighbours the refugee camps in the West Nile district of Arua, Dr George Ngapare, the health facility's inspector, decries the high turn up of refugees, leading to shortage of drug supplies.

"A mother here needs between Shs80,000 and Shs90,000 to fuel the ambulance in case of a referral to Arua

Regional Referral Hospital, about 80 kms away. However, in most cases the mother has no money, which leads to delays as they try to look for it," Dr Ngapare notes.

Staffing gaps

The 2017 Health ministry report puts the national recruitment rate of anesthetic officers at 28.9 per cent. Similarly, the number of health workers per 1,000 people in Uganda is still far below the World

Health Organisation threshold of 2.3 doctors, nurses and midwives per 1,000 populations.

Currently, the ratio of doctors, nurses and midwives to the population stands at 1:28,202; 1:2,121 and 1:6,838, respectively.

Ms Harriet Nakazzi, a nursing officer at Mulago hospital, says the congestion in public hospitals makes it difficult to ensure proper monitoring of mothers to identify complications during antenatal,

A midwife's day in a congested delivery suite

For the last 15 years, it has been a daily routine for 44-year-old Alice Collette Alum to be at Mulago Hospital's labour suite to deliver mothers.

Ms Alum, who now works at Kawempe hospital where Mulago's gynaecology and obstetrics ward has since shifted, speaks of her job as a tedious but satisfying experience.

Being a referral hospital, the midwife says she handles all kinds of mothers who come at different intervals with different conditions ranging from normal, mild to critical, with most of the critical cases coming from lower health centres.

"When due mothers arrive at the labour suite, after being screened by the person at the

registration desk, emergency cases are separated from those which can wait. Other mothers are already in labour while others are in danger with complications like preeclampsia and need to be given extra care," Ms Alum says.

In the labour suite, there are always different categories of mothers separated in different cubicles to be handled by particular nursing midwives at a time, according to their conditions.

All these cases are handled by eight midwives, each handling at least 10 mothers at a time.

"But you can even be four or three or two because some people go on leave and others for further studies, which is overwhelming," says Ms Alum.

"Sometimes we even fail to prioritise although there is always a midwife to call the doctor in case of an emergency," she says.

The same schedule continues even when she is on the night shift, which she sometimes extends to morning by several hours because they cannot leave without finishing what she has started. "Sometimes you are alone but mothers are pushing at the same time, so you can't just stop on the way," she says.

Ms Alum says the shortage of sundries, oxygen and beds increase their workload as they have to work extra hard trying to improvise to save babies and their mothers, including foregoing meals.

"We have no breaks I would say.

At times you want to take tea break but an emergency comes in and they call you. The same happens as one tries to have lunch. At times you go the whole day without eating," she says.

Ms Alum says despite the dedication and efforts, their remuneration has not improved over time. "The only thing that motivates me is assisting a mother and she goes back home with her baby happy."

Although Ms Alum has since attained a Master's degree in Nursing and Midwifery, her qualifications do not exist in the public service structure and she continues to practice at a diploma level.

By Lilian Namagembe