Mulago Report

September-October 2011

The past six weeks have been very busy and I'm gaining a wealth of experience. I feel that I am really settling in now and people are getting to know me. My biggest challenge so far has been adjusting to and learning to cope with the different attitudes of the staff. In particular I am realising that motivating the staff, especially the midwives is very difficult. Below I have summarised some of the issues I have encountered and projects I have been working on over the past 6 weeks.

Kabubbu Health Centre

At the end of September myself and an LMP representative (Karen Onions) visited Kabubbu Health Centre, just north of Kampala. Kabubbu HC is part of the Ugandan Obstetric 'Hub' and our aim was to firstly do an initial bench-marking report and then to evaluate their maternity services. The evaluation included a community survey which was an amazing opportunity to visit local women in their homes. We were able to identify some of the reasons why women were not delivering at Kabubbu. The main issues concerned the attitude of the staff and the lack of confidence the midwives had in their own abilities. We also visited Kasangati Health Centre as this seemed to be the most preferable choice for the women of Kabubbu to deliver. The atmosphere at Kasangati was very different and the midwives seemed empowered and enjoyed their jobs. I have outlined a re-training programme for the midwives at Kabubbu and also a community health programme. My first visit back to Kabubbu will be in on 17 November when Louise Ackers and Carol Porter visit from the UK.

Labour ward and triage

I am gaining a lot of experience on the labour ward, often not in the most appropriate circumstances. I often feel that there is a lack of senior presence and I have at times felt unsupported and frustrated. For example I found myself managing a PPH alone, because there were no other doctors around and the midwives offered no help. I had to leave the patient bleeding whilst I went on the hunt for ergometrine or misoprostol which wasn't in the drug trolley. It took me about 10 minutes to find some ergometrine which in the end I had to borrow from theatre.

Triage seems almost non-existent. Women still wait in a queue and are seen on a first come basis. Interns and JHOs are frequently left on their own in the admissions room to manage some quite complex obstetric cases. I strongly believe that there needs to be permanent senior presence on the labour ward to offer teaching and support to the junior staff. We also need to encourage the juniors to seek help early before a situation spirals out of control.

Midwife teaching

I am still finding that despite my best efforts midwives are not attending the teaching. I advertised for over a week for neonatal resuscitation training and only 3 midwives turned up. I also prepared training on the use of partograph however no midwives turned up. I'm not ready to give up yet and I have been in communication with the previous Eleanor Bradley Fellows and will hopefully come up with some more ideas to get the midwives involved. I have also had a discussion with the matron in charge and she has ensured me that she will make the midwives attend all teaching sessions.

Medical student teaching

I am now regularly teaching the undergraduates. With every new group of students I am teaching neonatal resuscitation and instrumental delivery. I find this really rewarding as the students are very enthusiastic and keen to learn.

AMEWS

With the help of a research midwife we have been able to complete the pilot study. The results are still to be analysed. There have been numerous problems collecting the data. Firstly the midwife collecting the data had to do the majority of the observations herself and struggled to find patient files. I have given several presentations and spoken to midwives individually about the AMEWS but many of the midwives and some doctors are still unaware of the AMEWS scoring system and how it is used. I think that continuous support and guidance is needed to enable the system to be incorporated into daily practice.

LMP visit

This month Jonathon Herod and Emma Silker from the Liverpool Women's Hospital visited Mulago to evaluate the gynaecology oncology service and the gynaecology wards (5A and 5A annexe). Their visit has been really helpful and will hopefully path the way to improving the somewhat neglected gynaecology wards. Of all the maternal deaths at Mulago since January 2011, 55% of them occurred on the gynaecology wards. Septicaemia (from septic abortion and puerperal sepsis) was the most common cause of death. The main problems seem to be the poor staffing ratios, lack of resources, and inadequate monitoring of the sickest patients. Currently the sickest women are being transferred to the obstetric HDU if there is space. One of the ideas we have been brainstorming is whether there is scope for a gynae HDU?

Lack of Supplies

The lack of supplies is a daily struggle. The most concerning is the lack of sutures especially in the obstetric theatre, meaning that emergency caesareans are delayed. Urinary catheters on the labour ward are also hard to come by, labour ward needs approximately 30 catheters per day. The drug trolley on the labour ward is virtually empty, with only oxytocin, antibiotics and fluids available. Particularly concerning the shortage of second line drugs for the management of PPH. Since misoprostol is so hard to get hold of, I wonder whether it would be feasible to get a small fridge to store some ergometrine?

And finally…

I am really enjoying life in Uganda. I have a great group of friends who are very supportive especially when I've had a tough day. I have found a good balance between work and rest. I am taking time to exercise and I walk to and from work every day. I am also getting out of town on the weekends to explore. Work for the next few weeks should be really interesting. I'm planning on spending a week in the fistula camp based in Mulago. This will be a great opportunity for me as I have never encountered obstetric fistula in the UK.