

Clinical visit to Mulago National Referral Hospital, Kampala, Uganda

September – November 2013

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I have spent 3 months working at the department of obstetrics and gynecology at Mulago National Referral Hospital in Kampala, Uganda. Mulago is the largest hospital in the country and is publicly funded meaning that services for patients at the hospital are free. This said it is still not entirely free for a patient to be treated at Mulago because she will likely have to buy her own medicines if the ward pharmacy is out of stock of what she needs and pay for her own ultrasound and lab work if the doctor requests tests which are not done at the hospital's own lab (or the hospital's lab machine is broken on that day). The patient is also required to bring all of her own bedding, clothing, food and in the case of a pregnant woman a "mama-kit" which contains sterile gloves, cotton, a basin etc to be used during the delivery. The hospital officially has 1500 beds but in reality about 1790 beds and at any given time between 2000-3000 in patients (those without beds stay on the floor). They treat about 6000 outpatients daily. The hospital was founded in 1913 with Old Mulago being a maze of many freestanding buildings up on the hill. New Mulago is a large 6 story building with 3 wings at the bottom of the hill which was finished in 1962, just days after Uganda's independence from the United Kingdom.

The department of obstetrics and gynecology makes up the entire 5th floor of New Mulago as well as a few buildings up in Old Mulago. There are also 2 private patient wards up on the 6th floor where those who can pay for better care do so. I have spent roughly half of my time on obstetrics seeing both the low-risk and high-risk labour wards, antenatal wards, labour theater, High Dependency Unit (a mini intensive care ward for the 6 most sick obstetric patients) and postnatal wards. The Labour Suite is often referred to as "the busiest place on earth" which I have found to be an accurate description. On average there are about 60-70 deliveries a day of which approx. 20-25 are caesarian sections. In addition to this there are about 25 more deliveries daily in the low-risk labour ward up in Old Mulago. I spent most of my first 2 weeks in the high-risk labour ward just observing, following the rounds and trying to understand how the doctors' and midwives' work is organized and how they evaluate and treat the patients. After those initial weeks I adjusted to my new setting and was able to more actively participate in patient care, assisting with the rounds, delivering (or rather catching...) babies and assisting in surgery. The second half of my time here has been spent on gynecology, gynecology and urogyn participating in ward rounds, surgery, admissions and the different out-patient clinics.

I have had the opportunity to see many patients during my months here and learnt more about both common diagnoses from home as well as illnesses which are much rarer in my home setting. The neonatal and maternal death rates are high at Mulago with on average 4-7 stillborns daily and 3 maternal deaths per week. The most common causes of maternal death are eclampsia, uterine rupture with major blood loss and post-partum hemorrhage. Obstructed labour and contracted pelvis are 2 very common diagnoses on the labour ward which I rarely see at home in the same way. Caesarians are done on most of these patients but since the waiting list for emergency caesarian is

often quite long some deliver vaginally. Most patients wait 8-12 hours and sometimes a couple of days from when the decision to do an emergency caesarian is made until the patient is actually on the operating table. If the patient is critically ill such as a cord prolapse or antepartum bleeding the time might be shortened down to 1-3 hours but never will a patient be able to get into the operating theater as fast as even our "non-urgent" emergency caesarians in Sweden do. Delivery is generally monitored only sporadically with a vaginal exam and auscultation of the fetal heart sounds on arrival and thereafter when rounds are done (3-4 times per 24 hours in high-risk labour ward and 1-2 times per 24 hours in antenatal and preeclampsia wards). The patient is generally left to take care of herself during the entire labour progress as attendants are not allowed to enter the labour suite and the midwife/doctor/student who will deliver will generally only approach the patient when she starts looking like/making noise indicating the baby is on its way out. Many of the patient charts contain partograms but they are only rarely used and round notes are all hand written and very repetitive with the background and history being repeated once or twice per note and several times per day making it hard to quickly find the newest and relevant information. In gynecology the most common patients are women who have incomplete abortions both spontaneous and illegal. Misoprostol is now readily available at pharmacies without prescription which has reduced the frequency of other "creative" methods of trying to do an illegal abortion but many women still take it in the wrong doses and very late in the pregnancy. Most "incomplete" abortions are treated with manual vacuum aspiration (MVA) even though they have misoprostol available and also without prior proper diagnosis since far from all patients have ultrasounds to confirm that a small bleeding really is a miscarriage. This likely means that several women with wanted pregnancies undergo unnecessary abortions because no one has checked to see if the fetus is still viable. Likewise many women who might have spontaneously bleed out the remaining products of conception are within less than a day treated with MVA greatly increasing the risk of perforation, infection and future infertility. Due to the use of sharp curettage and minimal training of the intern or nurse performing the MVA perforation, infection and Ascherman syndrome are much more common in Uganda compared to in Sweden.

I worked closely together with the local residents or SHOs who are the backbone of patient care at Mulago. While there are many specialists working in the department of obs & gyn they are very rarely seen on the wards. Each day there is one specialist assigned to labour suite and one to the emergency general gyn ward. These are supposed to be on call for 24 hours but many days they are never seen on the ward and sometimes not even reachable by phone. The medical students, interns and residents all have very extensive theoretical knowledge with a lot of time spent on lectures and research projects but actual hands on practical teaching is at a minimum. For example I asked one resident how he learnt to do caesarian sections and he explained that he had early on as a clinical officer (after one year internship) worked at a hospital where a more senior colleague operated with him for 2 weeks before he was left to do the surgeries on his own. He has since then done many hundred caesarians before even starting his residency and has now learnt a lot from his own mistakes but likely at quite high costs for his patients who don't always survive. He was quite proud of this as many of his colleagues don't even receive that much practical teaching... I learnt that the quality of work done varies a lot depending on the individual and in general I don't trust results of examinations written in a patient chart unless I know exactly who has done the previous exam. My attempts to fill out the partogram based on previous peoples exams often resulted in a zigzag with the cervical dilatation going up and down several times. One of the challenges early in my time at Mulago was getting used to now always having a more senior colleague at hand to discuss with or

ask for a second opinion. On gynecology this was somewhat better as the specialists are more present in the out-patient clinics, on urogyn and gynecology.

All in all the experiences I have had here in Uganda are of great value to me and I know I will have much use for them in the future. The main thing I have learnt is that it is not so much the lack of money or material resources which limits the quality of care in Uganda but instead the organization, culture and sub-optimal use of the people working at the hospitals. It has been interesting to see the everywhere obvious signs of foreign aid put into individual projects (mostly aimed at women's and child health, malaria and HIV) while at the same time the current structure and organization isn't capable of making use of the things which are donated. I have for example seen many doptones and a CTG machine which are available but often locked up in a storage room so that they won't be stolen and thus not used. There are fortunately also examples of material resources which are being very well used and these are most often associated with a person or group of people who are also involved in clinical practical training over a long time period and work to make structural changes in the organization.

To anyone reading this who is in a decision making position regarding foreign aid to developing countries I highly recommend not spending resources on material or short-term projects but instead on organizational consultants and projects aimed at making long-term changes in organization structure and culture. This is a much bigger challenge but the lasting effect on the health of the people of Uganda will be much more worth it in the end.

Summarizing 3 months in one short report is an impossible task so if anyone is interested in knowing more about Mulago, Kampala or Uganda please feel free to contact me.

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