Reflections on healthcare experiences during an elective to Rukungiri, Uganda

Experiencing nursing, midwifery care and nurse education in Uganda gave me a whole new world perspective on nursing. I observed many nurses, dealing with limited resources, who were dedicated to their patients, who recognised the importance of the role of the family in recovery and who were very skilled at clinical assessment. It made me realise how much, in both nurse education and the NHS, I take those resources for granted.

Liz Crathern MHP Ed, BSc(Hons), DipN, RGN, RSCN, RNT
Lecturer in Neonatal and Child Health University of Leeds
e.crathern@leeds.ac.uk

I travelled to Uganda in September 2007 for two weeks as part of a team with the British-based charity Mission Direct. I had never been to Africa before and the journey from Kampala, the capital, to the south western town of Rukungiri was overwhelming for two reasons. One was the outstanding beauty of the country – Winston Churchill called it the pearl of Africa and I could see why. The other was the level of abject poverty and the limited resources, by Western standards, which people had to endure. However, I immediately felt at home there, and that took me by surprise, as I was living without my home comforts – which meant no running water, limited, unpredictable electricity supply and mostly local food. I also had to get acclimatised to the notion of 'Africa time' quite quickly. This meant I had to learn to become less impatient about punctuality. Having just the bare essentials caused a refocus on what was important in my own life. I found the local people incredibly happy, whatever their circumstances, willing to help you and so thankful that you had chosen to visit them and support their projects.

My aims for the trip included:

- To observe health care in a developing country
- To create links with the nurse training school and teach student nurses
- To assess the potential as an elective placement for School of Healthcare students on an international module
- To work alongside the charity Mission Direct and explore possible medical and nursing electives
- To gain a unique cultural experience

It is important for anyone who intends to embark on such a trip to do some background research to understand about the country and its particular challenges in terms of health care. Fifty percent of the population are less than 15 years old and it is estimated that there are a million orphans. This is compounded by the fact that 0.5 million people have HIV/AIDS and general life expectancy is around 45 years. Grandparents who are very frail are left to pick up the pieces when family members contract HIV and are dying from AIDS. This presents huge challenges in terms of health education, sex education, caring for children's health needs and general family well being. There is also a population growth rate of 3% a year. However the average family size has reduced to 6.9. The Ugandan government have health targets they are trying to achieve by 2025, with interim targets that focus on reducing the HIV epidemic, childhood diseases, malaria, tuberculosis, infant deaths and maternal deaths. According to the Ugandan health department maternal and neonatal conditions constitute the highest total cost burden for ill health and avoidable deaths:

- Infant mortality rate = 88/1000 live births
- <5 years = 152/1000 live births
- Maternal mortality rate = 502 per 100,000 deliveries

I observed maternal and neonatal healthcare in Nyakabale hospital, and in the rural clinics (**FIGURE 1**). All medical resources were sparse, so items were cleaned and reused. Electricity supply was limited and unpredictable and in some instances there was no running water. Nyakabale hospital was originally a mission hospital and is still supported by mission doctors, administrators and nurse educators. It has a large outpatients department and maternity wing and requires patients to make a small payment towards treatments including maternal care. A normal delivery costs 4000 USh (£1.20) and a caesarean section 30000 USh (£9.00). To put that into perspective the average daily wage is around 1500 USh (50 pence). The maternity ward was very busy on the day I visited with lots of relatives supporting the new mothers. This is very important as most rural hospitals will struggle to provide any food. It is also expected the family, not nurses, will provide all the fundamental cares such as washing and feeding, including changing bed linen, which they bring in

FIGURE 1 Liz Crathern outside the rural clinic in Buhunga, Uganda.

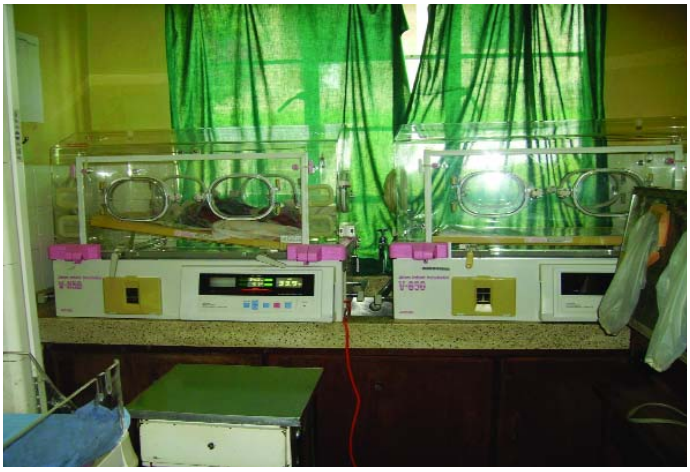

FIGURE 2 Incubators in the SCBU at Nyakabale hospital.

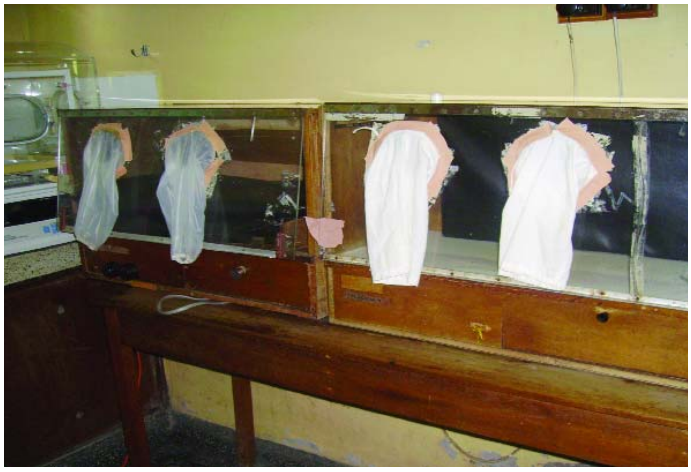

FIGURE 3 The traditional warming incubators in the SCBU.

themselves. From a cultural perspective, it helped me to understand better why families from other cultures living in the UK want to be close to their relative in hospital all of the time and care for them by supplying home made food. All over the hospital grounds you could see the family attendants washing bed linen. I was also shown the special care nursery (**FIGURES 2 & 3**). It consisted of one resuscitaire (without equipment), two donated incubators and two traditional warming incubators, powered by two standard light bulbs. It resembled a small cupboard. This was a very moving moment for me, as looking at it through a western lens there seemed very little the nurses could do to improve the lot of sick babies in their care. In one of the modern incubators I noticed a baby, said to be 28 weeks, but who actually looked about 32 weeks. He was in this room alone and had breathing difficulties. I asked the administrator to call a nurse. She did come and informed me his care was simply to be kept warm and to be breast fed.

Nevertheless the people and children in these healthcare settings were getting a level of care that was beginning to improve their overall heath and well being. It is difficult to compare to a western health system and I decided very early on not to make these comparisons. At least in that hospital if a preterm baby was delivered and breathing they could keep the baby warm and feed with some breast milk. This very basic intervention could literally save an infant's life. However, I did also note that there are many children in the region disabled as a result of the stressors of pregnancy and birth. It was a humbling experience and challenged me to address issues around intervention at or below the edge of viability.

Health centres aim to provide maternity care close to the mother's village. Before the introduction of health centres, if a woman went into labour she often had to walk many kilometres to the nearest hospital. In the health centre the woman is attended to by a trained nurse midwife and a student nurse with 24 hours care and observation post delivery. The problem is attendance at these clinics needs to improve radically, this is partly cultural with some families still relying on traditional healers. Inadequate funding of all drugs in clinics means resources run out quickly, including treatment for malaria and antibiotics. When visiting the midwifery clinics in the field I observed posters and information for fathers about the need to reduce the number of pregnancies a woman endures. One poster graphically explained the likely health deterioration for the mother in terms of co-morbidity. However in the two days I spent at the midwifery clinic I never saw a woman accompanied by her partner. I did observe student nurses undertaking very complex nursing and midwifery tasks and was impressed with both the amount of clinical experience these young students were exposed to and the tutorial support they received in the field, working closely with the trained midwife. The reflective session with the students identified very different concerns to those of UK students, including not having enough drinking water, milk and kerosene for their lamps. Talking to the students you could sense a real pride in their role and uniform as they looked forward to qualifying and becoming a nurse (**FIGURE 4**). Nursing as an occupation carries status in that society. However, much still needs to be done to improve their lot as a profession in terms of salary and working conditions.

Increasing the number of nurses in rural health centres is one of the government targets. This has meant training and curricula

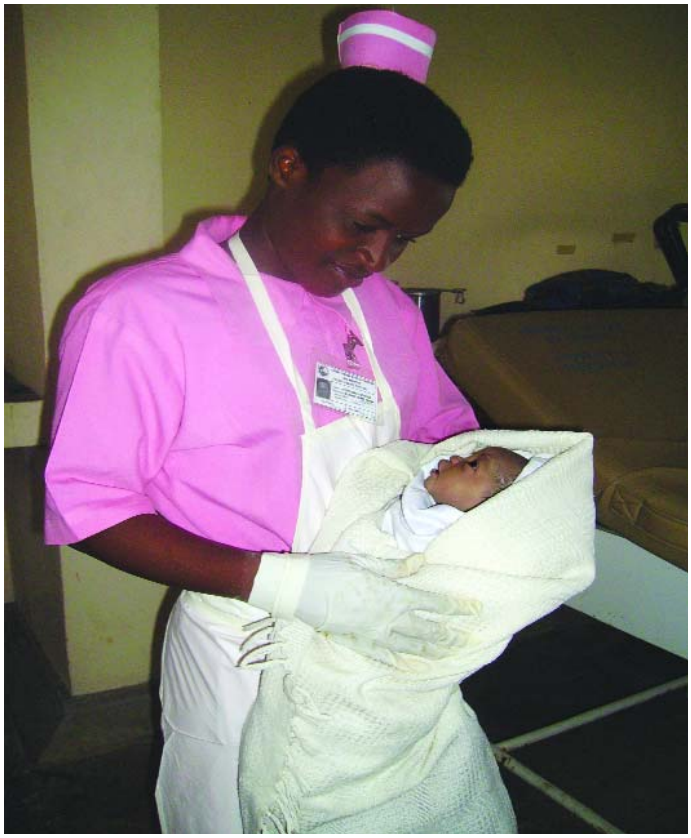

FIGURE 4 A student nurse in a rural clinic.

have had to be changed to meet those needs. Student nurses train for 30 months as both enrolled nurses and midwives, equipping them with the skills needed to attend to patients from 'the cradle to the grave'. I was fortunate to spend time with the two senior lecturers on my field trips, which generated interesting discussion about nurse training and education in both countries. They did not have a paediatric tutor at Nyakabale hospital training school and they were happy for me to undertake some neonatal teaching. The challenges included waiting for the torrential rain to stop and see if we still had electricity, and adapting my session on neonatal care to meet local care delivery, whilst still pushing the boundaries of their personal learning. English is the spoken language in the school so I did not have a problem being understood. However, I did have to take time to allow the students to make notes. All forms of paper were in short supply, as was any technical support including computers. The library was very small and really under resourced. Students relied on their own notes for revision.

This short reflection has been an attempt to discuss some of my experiences. Would I do it again? Did I learn from it? Is it a good elective for students and trained staff alike? "Yes" to all those questions.

I am planning to go back to Rukungiri in August 2008 for three weeks to contribute to neonatal and child health teaching at the school. This time, I am being accompanied by Denise Evans, one of the regional educators within the Yorkshire neonatal network. We also intend to visit Rugarama hospital in the region that has a SCBU which is hoping to become a referral centre as well as the Life Learning Centre for children with brain damage. If you have ever thought about doing something like this but always felt it needed more time, Mission Direct will take people in teams for two weeks. Have a look at their web site or contact medical mission volunteer manager Lucy Luget tel 01582 720056 email Lucy.Ludget@missiondirect.org.

Acknowledgement

I would like to thank Leeds University for supporting my elective and all the various fundraising support, including an educational grant from the Learning Curve Nutricia, and the students and staff of Nyakabale School of Nursing. Please feel free to contact me if you want to know more or if you have any books, journals or SCBU resources you would like to donate for our next trip.

Further reading

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