#618211

Access to Basic Healthcare for Uganda's poorest

Access to Basic Healthcare for Uganda's poorest 1
The Appeal Target: £35,000 2
Background 2
Health and Poverty in Uganda 2
Health and Poverty Globally and VSO 3
VSO's Approach 3
VSO's Health Programme in Uganda 2008-12 4
Why is VSO working in Health in Uganda? 4
What makes VSO's work in this programme area special? 4
Who else is backing VSO's input to this project? 4
Key beneficiaries and partners 4
Key objectives of the VSO Health programme and cross-cutting themes 5
Programme activities 6
Focus of International Volunteer Placements 6
Key objectives of the VSO Health programme specific to Uganda 6
Funding 8

CASE STUDY 9
Volunteer Paul Williams 9
– Doctor at Bwindi Community Health Clinic, Uganda 9
SUMMARY OF BWINDI COMMUNITY HOSPITAL'S ACHIEVEMENTS BETWEEN APRIL 2006 AND JUNE 2008 WITH PAUL'S HELP 9
Bwindi Community Health Centre Annual Report 2007-2008 (Extract) 11
Paul's First Update, August 2006 12
Paul's Second Update, November 2006 12
Paul's Third Update, April 2007 13
Paul's Fourth Update, August 2007 14
Paul's Fifth Update, February 2008 15

Rachaela, a child suffering from malnutrition, being looked after by VSO volunteers Paul Williams and Vicky Holt and colleagues at Bwindi Community Health Centre, Uganda.

All statistics sourced from www.who.int and www.unicef.org

The Appeal Target: £35,000

VSO aims to meet this target through donors giving directly via Global Giving to health work carried out by our volunteers in areas of Uganda which need us most.

The broader VSO Health in Uganda project (2008-12) will cost significantly more than this, and VSO is grateful to all its donors, individual, Volunteer Linkers, corporate partners, trusts and the Department for International Development for their vital support in our work.

Background

Health and Poverty in Uganda

Uganda is one of the world's poorest countries, with more than four out of every ten people struggling to get by on less than 50p a day. The quality of health care and education is low, particularly in rural areas, and life expectancy is just 53 years. There are only five qualified doctors for every 100,000 people in Uganda, compared to 210 for every 100,000 people in the UK.

Most of the diseases that afflict the population here are directly related to poverty. … Young girls get HIV because they are so desperate for money that they prostitute themselves to the soldiers who are in the area to protect the tourists visiting the Impenetrable Forest (one of the hidden costs of Gorilla tourism).

VSO Volunteer Paul Williams, August 2006

Almost one in every six children in Uganda is an orphan. This is principally due to the ravages of HIV and AIDS. Indeed, at current rates of infection, two in every ten children will contract HIV and AIDS when they are adults. Childhood diseases such as diphtheria, polio and whooping cough that we think of as things of the past in the UK are also killing thousands of children every year in Uganda.

While treatment of specific clinical conditions meets an immediate need, a brighter future for Uganda lies in education and training in healthcare practice, disease prevention and primary care.

Much of VSO volunteers' focus is on disseminating their skills and knowledge to local health workers, and consequently the local population, and in training local professionals to do the same after the volunteer departs.

The volunteers' work usually has an immediate impact on health issues, such as infant and maternal mortality rates. However, the success of their time in their placements is reflected principally on the legacy they leave behind. This generally stretches the volunteer's input far beyond purely medical input (for example a heavy commitment to human resources, capacity building and fundraising for the long term) and they are selected before they go for their problem-solving skills as well as their professional health expertise. VSO volunteers have long been extremely highly regarded in the sector and VSO itself was voted top international development charity at the Charity Awards 2004 for its work.

VSO volunteer health professionals are well aware that the future of the region depends on a better local understanding of the health risks the population encounters and the steps they can take to minimise those risks. The charity's approach maximises both the appeal for skilled professionals to stay practising in their home country where they are vitally needed, and in the long-term addresses fundamental problems such as the loss of slow-to-replace health professionals themselves to HIV & AIDS.

All statistics sourced from www.who.int and www.unicef.org

Health and Poverty Globally and VSO

There is increased international political recognition that poor health is a serious global development challenge. Poor health keeps people in poverty and leads to increased economic, political and social instability, especially in the most disadvantaged countries. Globalisation presents 2 key challenges. The risk of spread of communicable diseases such as HIV, TB and influenza is increasing and there are increasing health inequalities between developed and developing countries that impact especially on the 1 billion people living on less than $1 per day.

Recommendation 5

- ***Reviewing arrangements to improve opportunities and remove disincentives for health workers to volunteer with VSO***

Global Health Partnerships – The UK Contribution to health in developing countries, Nigel Crisp, February 2007

Overcoming the challenges presented by the threats to global health requires an international response. As a result there are increasing opportunities for VSO to build on nearly 50 years experience of fighting disadvantage and to make a positive contribution towards tackling health inequalities.

That VSO has a role to play was recognised by Lord Crisp in his influential report - 'Global Health Partnerships: The UK contribution to health in developing countries' (February 2007: www.dfid.gov.uk/Pubs/files/ghp.pdf). This was highly significant because it included recognition of the positive impact that volunteering in general and VSO specifically can make and recommended schemes to boost VSO's input, which are now being put into place.

VSO's Approach

VSO is the leading overseas development charity that works through volunteers. Instead of sending food or money, it sends skilled professionals to some of the poorest countries in the world to help save and change lives.

The standard VSO volunteer placement is designed to last for 2 years. Many VSO volunteers extend their placement in order to progress their project further. They are given a daily allowance of £5.20 or equivalent to meet their basic living needs, and many volunteers contribute some of this allowance towards items more directly related to the work they are doing. The volunteers represent extraordinary value unmatched by any other kind of professional consultancy.

VSO works throughout Asia and Africa responding to requests from community organisations, poverty alleviation schemes, training institutions, governments and other diverse organisations. Over the last 50 years VSO has been helping disadvantaged people work themselves out of poverty through long-term development.

VSO's goals cover Health & Well-being, HIV & AIDS, Education, Disability, Secure Livelihoods and Participation & Governance in 37 countries.

Over the past 50 years, the charity has sent nearly 35,000 volunteers – including doctors, teachers, agriculturalists and business professionals overseas to pass on their skills and knowledge to local people and to learn and share with them best practice.

VSO's Health Programme in Uganda 2008-12

Why is VSO working in Health in Uganda?

The poor and disadvantaged in Uganda continue to be badly affected by preventable diseases while the quality of health service provision continues to be poor. There are also many challenges relating to retention of health staff.

The public are not mobilised or motivated to demand quality health services from both the public and private sector. VSO is supporting the Uganda Health Sector Strategic Plan (HSSP) which aims to improve health systems following the decentralisation of health delivery to District level. HSSP has a strong focus towards working with communities and implementation of primary health care services, particularly in rural areas where access to health care is a major issue.

What makes VSO's work in this programme area special?

VSO has been working in health care in Uganda for many years and has an established presence in the country. The creation of a dedicated Health programme area in Uganda means that the work can be more focused towards specific objectives in partnership with the Health Sector Strategic Plan. This HSSP is focused on poor people through primary health care and prevention, which are areas in which VSO has much expertise and experience within other health programmes. VSO is also incorporating a rights-based approach to health services, which is seen by all partners as an essential part of a health strategy.

Who else is backing VSO's input to this project?

VSO initiated a partnership with the NHS in Scotland (where volunteers were required to work in health and HIV & AIDS programmes in Sub Saharan Africa) and is exploring a partnership with NHS England which should support the expansion of the Uganda Health programme. With support from the UK Government's Department of Health, VSO is also being encouraged to develop its health volunteer provision.

Key beneficiaries and partners

Beneficiaries:

- The population of districts where VSO Uganda works
- Health Professionals who will be supported and trained by VSO volunteers
- District Health Management
- People living with HIV & AIDS
- People potentially affected by communicable diseases

Partners:

- Health Services in Districts and health Sub Districts where VSO is currently working
- Health Training institutions
- Private Sector: International Medical Group, Case Medical Centre
- Not for Profit Sector: Hope Clinic Lukuli, Reachout Mbuya, Comboni Hospital, Bwindi Community Health Centre
- Health consumer organisations: Health Action Group, Coalition for Health Promotion and Social Development (HEPS)

Key objectives of the VSO Health programme and cross-cutting themes

1. Increased capacity of health professionals to provide effective health services to poor and marginalized groups, especially women.
2. To improve the management and delivery of essential services.
3. Increase health promotion activities and support for improved public health.*
4. Increased advocacy for poor and marginalized groups, especially women, to realise their rights to health, and to good quality health services
5. VSO will increase the number of health Programme Area Plans and/or expand current health Programme Area Plans to support health care development

HIV & AIDS and Gender are cross cutting themes:

- Despite reductions in HIV & AIDS prevalence (from 30% in 1986 down to 6% in 2004), prevalence is now increasing again and is seen to be disproportionately affecting women. Numbers of people affected by HIV & AIDS have overwhelmed health systems and structures which are themselves losing slow-to-replace health professionals to HIV & AIDS. The cost of treatment and support has shot up and the country is reliant on donors.
- Despite the current government implementing a gender equality policy, in general the status of women in Uganda remains low. Female children are more likely to drop out of school at a young age, 43% of pregnant women are teenagers and maternal mortality rates have not improved in the last 10 years. Women are also very dependent on men to pay for health services making the services less accessible to them particularly emergency reproductive services.

***Example (& see p.14)**

3.2 Indicator: Improved links between primary health care providers and communities

Prevention of Malaria at community level led by a VSO Volunteer, Bwindi Community Health Centre

Malaria is the biggest killer of patients, the most common diagnosis made, and accounts for the largest expenditure on drugs at Bwindi Community Health Centre in South West Uganda. It causes high staff absenteeism due to sickness and child mortality, is the cause of most of the demand for blood supplies and takes up much of the centre's laboratory time.

Prevention through use of an insecticide-treated bed net (ITN) is one of the best ways to avoid contracting malaria. However, an economic analysis found that they were priced out of the range of the poorest and most vulnerable. It was found to cost between 12,000 and 15,000 shillings (£3-£4) for an ITN. A VSO volunteer doctor and his colleagues found a way to help the people around Bwindi to access ITN's at affordable prices.

Contact was made with 'Soft Power Health' and support gained from an American doctor who ran a basic primary care service. A joint programme of malaria education and bed net sales was organised for Bwindi parish. The VSO volunteer also worked closely with Bwindi Health Centre community health workers to mobilise communities and inform people through churches, and to get the local radio station to broadcast details of the programme.

Permission from local council leaders to carry out the programme was granted. At each village session, mosquito nets were hung to attract the attention of passers-by, and church drums were played to inform everyone that proceedings were about to begin. Health centre teams gave presentations on the causes of malaria and how to use bed nets. Only people who attended the education sessions were entitled to purchase nets. Bed nets were not given away but sales were subsidized at 3000 shillings (80p) each, because it was felt that people needed to value their nets in order to use them. In the poorest remote villages, everyone agreed the price of a bow-and-arrow or 600ml of honey

Altogether 1000 Insecticide Treated Nets were sold in 3 days, and there was demand for many more. Plans were made to repeat the project as soon as possible and a date set, with the aim being to distribute another 1,000 nets.

Programme activities

Focus of International Volunteer Placements

- Currently, volunteer placements focus primarily on provision of health services. Doctors are required to support District health services, Mission Hospitals and Not for Profit organisations. The focus of placements is on running out-patient departments, treating in-patients and supporting treatment of chronically ill patients, especially those with HIV & AIDS. There is an emphasis on linkages between the community and the health units with health managers taking an active role. This will require volunteers who have skills in primary care and community-based health services.
- With the implementation of the new Health programme, placements will be developed for doctors and nurses to work in primary health care, building the skills of health workers. There will also be placements for volunteers with public health and health management/administration skills and experience in Health Management Information Systems to support the management of health services at District level. Volunteers will also be requested to support and develop the skills and status of health workers in community and village health care programmes, working with Health Sub-Districts and NGOs.
- There are also a number of placements in Health Training Institutions including two Doctors based at Mbarara University and a Nurse Tutor at International Medical Group teaching their nurse training course. More placements will be developed for volunteers to train health professionals in Universities and nurse training schools and potentially laboratory training schools.
- Placements will be developed for volunteers to support VSO Uganda's partners in developing and implementing health rights advocacy strategies.
- VSO Youth for Development volunteers will be used to work with community based health volunteers.

Key objectives of the VSO Health programme specific to Uganda

Objective 1: Support public sector, private sector and private not for profit sector to provide quality and accessible health services with an emphasis on reproductive health services and communicable disease control particularly malaria and HIV & AIDS from 2008-12		
Partner Organisation	**Organisation's Mission**	**No. of Volunteers needed**
Bwindi Community Health Centre	Giving holistic health care and life in all its fullness to the staff, patients, clients and visitors in the hospital and community	2
International Medical Group/International Medical Hospital (IHK)	Making a difference in health care through excellence in service.	3
Mbuya Reach out	To provide holistic health care – medical, social emotional and spiritual support – to people living with HIV & AIDS in Mbuya Parish and to prevent further spread of HIV & AIDS in the community	1
Nsambya hospital	To provide quality medical care to all people at an affordable cost.	1
Buruli Health Sub-district Masindi district	To provide quality curative and preventive health services for the people of Buruli health sub-district, Masindi district	2
Kitagata District hospital, Bushenyi District	To provide quality curative and preventive health services for the people of Bushenyi district	1

Hope Clinic Lukuli	To provide health facilities for needy mothers and children in the Makindye area and to provide relief from sickness and distress by the provision of grants to assist community based health services to the needy community in the Makindye area.	1
Objective 2. The number of trained health personnel working with the health sector to implement the Uganda health policy and health sector strategic plan increased by 10% from 2008 to 2012		
Partner Organisation	**Organisation's Mission**	**No. of Volunteers needed**
Makerere University Kampala Speech and Language Therapy Programme	To produce qualified Speech and Language Therapists at all levels to assess, train, research, prevent and intervene in the areas of communication & swallowing difficulties for Uganda and further a field.	2
Mbarara University of Science and Technology (MUST)	To provide quality and relevant education at national and international level with particular emphasis on science and technology and its application to community development	1
International Hospital Kampala, school of nursing	A mission committed to excellence in provision of health care, compassionate nursing, high standards of medical expertise & professionalism, & to prepare students to meet the demands of an increasingly competitive future	1
Objective 3. Increase demand for better health services within the general population through the support of health rights activist groups with an emphasis on women and child rights from 2008 to 2012		
Partner Organisation	**Organisation's Mission**	**No. of Volunteers needed**
Acid Survivors Foundation Uganda (ASFU)	Acid Survivors Foundation Uganda (ASFU) was established in 2003 after the problem of acid violence in Uganda was widely acknowledged. It is the only organization in Uganda holistically addressing the gross violation of human rights, specifically the challenges faced by survivors of acid attacks.	2
International Medical Group	As above	1
Peace Education Trust	To contribute to the peace and human rights education of the disadvantaged citizens particularly children of Kisoro, Uganda	1
Reach out Mbuya	As above	2
Hope for Positive living (HOPOL) former Kinawataka HIV Women's Organisation	To improve the quality of life of positive women, their children and orphans and promote greater awareness and understanding of HIV & AIDS in Uganda	1

Coalition For Health Promotion & Social Development (HEPS)	HEPS Uganda works towards building of a society in which health consumers are informed and sufficiently empowered to demand for their rights and take responsibility for their own health	1
Health Action Group (HAG)	Health Rights Action Group (HAG) is a civil society organisation dedicated to promoting the human and health rights of people living with and affected by all diseases, in particular HIV/AIDS. Health Rights Action Group (HAG) is a civil society organisation dedicated to promoting the human and health rights of people living with and affected by all diseases, in particular HIV/AIDS.	2

Funding

VSO volunteers take time out from their careers to give that time and share their professional skills with people in VSO partner organisations. They live and work within the local communities, for up to two years (and longer if they extend their placements). They are required to work creatively and adapt to unfamiliar situations - often with few resources.

In order that the volunteers can carry out their work, VSO provides them with a basic living allowance to cover food, transport, clothing as well as costs incurred in the home country such as preparation costs, pension and National Insurance contributions. This is calculated at £5.20 per day. There are other costs involved in getting the volunteers selected, recruited and trained in their home country and then supported in-country. The bulk of these costs are met by VSO, while a small local salary is provided by the partner organisation, sometimes with support from VSO, and we are constantly raising funds to meet all of these costs.

Contributions to this appeal are calculated on the basic living allowance, and all donations received will go towards funding the volunteers working in the Health programme in Uganda.

CASE STUDY

The following pages give an insight into how supporting VSO's health work in Uganda makes a real long-lasting difference.

- **(pp 9-12) These extracts from the Bwindi Community Health Centre documents align the work volunteer doctor Paul Williams has been putting into the Centre with the progress to date and the immediate and future needs, achievable through the input of more VSO volunteer time and dedication.**
- **(pp 12-16) In these extracts from his updates, volunteer Paul Williams gives accounts in his own words, from his first months in 2006 to February 2008.**

Volunteer Paul Williams
– Doctor at Bwindi Community Health Clinic, Uganda

Doctor Paul Williams and his partner Nurse Vicky Holt started their 2-year VSO volunteer placements at Bwindi Community Health Centre in Uganda in April 2006. They have extended their placements until at least March 2009. The Health Centre was set up in 2003 by American missionaries Scott and Carol Kellermann. The clinic provides healthcare for an area covering 40,000 people.

The centre was set up particularly to help care for the local minority group, the Batwa who have been displaced from their natural home in the forest. They are some of the poorest people on earth. The under-five mortality for landless Batwa exceeds 60% and many women die in childbirth.

SUMMARY OF BWINDI COMMUNITY HOSPITAL'S ACHIEVEMENTS BETWEEN APRIL 2006 AND JUNE 2008 WITH PAUL'S HELP

STAFFING LEVELS EXPANDED FROM 15 IN 2006 TO MORE THAN 65 IN 2008. (Human Resources issues tackled including construction of a dining area and staff given break tea and lunch, and annual appraisals initiated. More than 30 staff have been on external training courses in various subjects during this time.)

BASIC HEALTH CARE PROVIDED (immunisations, antenatal care and deliveries)

WORK WITH MARGINALISED BATWA COMMUNITIES

EXPANSION OF HEALTH SERVICE TO PROVIDE HIV TESTING, PMTCT (Prevention of Mother to Child Transmission), AND FREE TREATMENT TO ALL OF THE PEOPLE IN KAYONZA AND MPUNGU

OFFERING QUALITY DIAGNOSTIC SERVICES FROM THE LABORATORY AND X-RAY

TEACHING ABOUT WATER AND SANITATION IN ALL SCHOOLS IN THE AREA

RUN INTEGRATED OUTREACHES EACH WEEK (with teaching about malaria and selling of subsidised mosquito nets)

COMMUNITY HEALTH TEAM TRAINING 28 VILLAGE HEALTH WORKERS IN EACH OF THE NINE PARISHES BCH SERVES (acting as representatives in 250 villages to detect malnutrition, improve sanitation and distribute family planning. Community and school dental clinics.)

Sexual and reproductive health

OPENED A MOTHER'S WAITING HOSTEL (to provide accommodation for expectant mothers who live far away and need somewhere to stay before delivery)

ESTABLISHED FIVE MIDWIVES WORKING IN MATERNITY AND IN THE COMMUNITY

REGULAR MEETINGS WITH AND TRAINING FOR TRADITIONAL BIRTH ATTENDANTS AND VILLAGE HEALTH PROMOTERS

STARTED PARTNERSHIP WITH MARIE STOPES INTERNATIONAL FOR PROVISION OF ENHANCED FAMILY PLANNING SERVICES

HIV/AIDS

MORE THAN 800 PEOPLE TESTED A MONTH

ALL HIV POSITIVE PEOPLE CAN ENROL FOR FREE CARE AND ANTIRETROVIRAL DRUGS

OUTREACH TO HUNDREDS OF PATIENTS AT FOUR SITES

ALL PREGNANT WOMEN IN TWO SUB-COUNTIES TESTED AND MANAGED TO PREVENT TRANSMISSION TO BABIES

FREQUENT SENSITISATION AND EDUCATION SESSIONS IN COMMUNITY

CONSTRUCTION OF NEW HIV/AIDS & TB OUTPATIENT BUILDING

Child Health

OPENED NEW CHILD HEALTH AND NUTRITION UNIT WITH A DEMONSTRATION GARDEN

REGULAR TEACHING SESSIONS FOR MOTHERS ON NURITION AND MALARIA PREVENTION

FINANCIAL SUPPORT FOUND FOR CHILD HEALTH AND NUTRITION UNIT

Outpatients, Dental and Eyes

CLINICAL SUPPORT WORKER APPOINTED TO ENSURE THAT WAITING TIMES ARE REDUCED

IMPROVED PATIENT-FLOW AND DIRECTIONS

Adult Inpatients and Diagnostics

LABORATORY IMPROVED WITH MACHINES TO TEST FOR SYPHILIS AND HAEMOGLOBIN

FIRE PREVENTION IMPROVED

TB TESTING MADE SAFER

X-RAY AND ULTRASOUND CAN BE DONE BY SEVERAL MEMBERS OF STAFF ON ANY DAY OF THE WEEK

Administration

DRUG STORE MOVED TO NEWER AND BIGGER LOCATION

DRAINAGE, WATER SUPPLY AND SANITATION SYSTEM DESIGNED AND CONSTRUCTION BEGUN

SYSTEMS FOR OUTREACH MANAGEMENT AND TRANSPORT MAINTENANCE OVERHAULED

NEW AMBULANCE & COMMUNITY TEAM VEHICLE

COMPUTER NETWORK INSTALLED WITH INTERNET ACCESS

CLEANING IMPROVED

STRATEGIC PLAN FOR HOSPITAL DEVELOPMENT FORMED WITH HUNDREDS OF STAKEHOLDERS PLANNING THE FUTURE OF HEALTH CARE IN THIS AREA

DATA COLLECTION SYSTEMS INTRODUCED

GOVERNANCE & FINANCIAL SYSTEMS IMPROVED INCLUDING EXTERNAL AUDIT OF FINANCES

PARTNERSHIPS WITH UNIVERSITIES AND SCHOOLS OF NURSING ENHANCED AND NEW ONES INITIATED.

OPERATING THEATRE DUE TO OPEN ON 1ST NOVEMBER 2008

Bwindi Community Health Centre Annual Report 2007-2008 (Extract)

During the last year, there have been many changes to the way that Bwindi Community Hospital is run. The Hospital has been organised into different Programme Areas. The Principal Administrator leads all of the non-clinical work (administration, human resources, finance and public relations). The clinical areas are led by the Principal Medical Officer and the Principal Nursing Officer. The office of Dr in-Charge became known as the Medical Superintendent in May 2008. This person leads the whole organisation and is directly accountable to the Board and the Management Executive.

The main task for the Medical Superintendent in 2007/8 has been to lead the organisation through a strategic planning process. This began through staff meetings in September and continued with more than 200 stakeholders joining discussions in October and November, including the Chief Administrative Officer and the District Public Health Nurse. All members of the Management and staff have subsequently been involved in drawing up the strategic plan for the next three years and the Workplan for 2008/9.

The Strategic Plan covers in detail, with measurable Goals, Indicators and measurement Tools all details of clinical and non-clinical programme areas.

The clinical areas are:

- Adult inpatients and diagnostics
- Byumba Health Centre II (firm plans to open a centre there in an isolated area 40 minutes drive from BCHC)
- Child Health
- Community Health and Batwa
- HIV/AIDS & TB
- Outpatients, dental and Eyes
- Sexual and Reproductive Health
- Surgery

The non-clinical areas are:

- Accounts and Finance
- Administration
- Human resources
- Public Relations and Fundraising

Relationships with the Diocese of Kinkiizi have been strengthened with attendance at the Bishop's Management Committee meetings and the Diocesan Synod.
Regular meetings have been held with the District Health Officer, and copies of the Annual Workplan and budget for 2008/9 have been submitted to his office. Data collection systems have been revolutionised, and computers are now being used for collection and storage of information in some parts of the Hospital. The accuracy of data has been significantly improved, data is displayed on walls and is discussed in clinical meetings, and reports are submitted in a timely manner.

Eight Key Areas of Need at Bwindi Community Hospital in 2008/09

Together with the Centre's founder VSO volunteer Paul Williams and his partner Vicky Holt aer fundraising for these areas temselves through private and corporate contacts. By supporting him and other health workers in VSO's Uganda Health programme, together we are able to lever funds and generate substantial sustainable support for this Health centre and other VSO partner health providers and training organisations.

- Building decent accommodation with water and power for staff
- Two new ambulances to run the mobile HIV/AIDS clinic and the Community Outreach programmes
- Support for the running costs of the services offered: inpatient wards, outpatients, dental care and the community health programme
- Funding for a Surgical service for Caesarian Section operations

- Improvement to the Hospital infrastructure with better drainage, landscaping, a fence, a mortuary and better waste disposal
- Construction of a new adult ward with better isolation and improved nursing facilities
- Support for the running of the HIV/AIDS & TB programme which, by the end of the year, will be providing treatment for 1000 people over 5 sites
- Staff salaries for 80 staff, which consumes 62% of BCHC's operating costs

Paul's First Update, August 2006

I've now been at Bwindi Community Health Centre in Uganda for the last three and a half months and thought it was time to send you a report on my work.

Most of the things that I thought would be happening here are not, and I've been amazed to find other things that I didn't ever anticipate. My most striking observations are the abject poverty of many of the people and the geographical remoteness of Bwindi.

Most of the diseases that afflict the population here are directly related to poverty. Children get malnutrition because people cannot afford nutritious food, and because they have poverty of knowledge about which crops to grow. They get malaria because even people who know about mosquito nets cannot afford them. Young girls get HIV because they are so desperate for money that they prostitute themselves to the soldiers who are in the area to protect the tourists visiting the Impenetrable Forest (one of the hidden costs of Gorilla tourism). Others get diarrhoea because, even though the area has plentiful water, the water sources are contaminated and nobody has the skills or funds to protect the springs.

I am really aware that Bwindi is a long way from anywhere. This is fine when everything is working well, but when a vehicle breaks down, the Health Centre runs out of a medicine or someone is really ill, the absence of a Plan B is striking. It takes nine hours on the bus to reach the capital, Kampala, which is the only place in the country where it is usually possible to get spares and supplies. One of the things that I will work on in the future is a better system of managing stock in the Health Centre so that we run out of things less often.

I am visiting Kabale today is to meet with an organisation that will train some of our nurses in counselling and testing of patients for HIV, and then supply us with free test kits. I have also written an application for a large grant to help deliver better (...any would be good) HIV prevention work in the area. These are the things that I really want to be doing, because I know that improving access to and delivery of primary health care ultimately makes much more difference to the health of a population than waiting until people become sick and then treating them.

Paul's Second Update, November 2006

This month there have been some real successes that show that our Health Centre is moving in the right direction. Bwindi Community Health Centre now has two Clinical Officers who are not doctors, but are trained to diagnose and manage most conditions. I hope that within a few months the Clinical Officers will run the Health Centre, enabling me to work mainly on Primary Care.

The Community Health Team has doubled in size from one to two. Both of them are from the local community. For the moment they are advertising the Child Days that we run throughout November – de-worming, giving vitamin A and immunisations to the kids, offering family planning, treatment of sexually transmitted infections and health education to the mothers. After this we will plan a programme to extend the TB work to new parishes and really try to take family planning into the communities. We will also, along with Evelyn the new midwife, have a meeting with Traditional Birth Attendants (TBA's) next week and a two-day workshop in December with them. Most deliveries of babies take place in the community.

We have had lots of students from Mbarara University over the last few weeks. This has been part of the strategy that Vicky and I have introduced. "Reduce the numbers of Western visitors", "reduce reliance on outsiders" and "increase the number of Ugandans exposed to our Health Centre" have been our three mantras. They will be the future of the Health Centre, and partnering with Mbarara University has been one of my few definite successes.

Paul's Third Update, April 2007

The Health Centre looks like a building site at the moment. There is some good news from the perspective of the work that I'm trying to achieve.

We are going to turn the future new surgical unit building into a Women's Health and HIV Centre until we have raised the funds for and built the Maternal, HIV and Sexual Health Unit. Within a week or two the new HIV clinic should be housed. At the moment I'm running it wherever I can find space.

The building formerly known as the Surgical Unit will also house a new delivery room and will be a home for the antenatal clinic. Last month we had 35 deliveries, increasing numbers in the antenatal clinics, provided drugs to prevent mother-to-child transmission of HIV to five women and gave family planning to 80. The decision to employ a second midwife has been vindicated, and it's now not possible to imagine how we would function with only one. I think that more women are coming to us because the quality of our service is really improving. Health promotion, early detection of problems in pregnancy and during delivery, and good access to postnatal services are all part of the gospel that I preach, and being able to watch these things happen is heartening.

HIV work is taking off here in a way that I never would have predicted the last time I wrote an update. More than 500 people have come for testing since the start of December, and about 14% of them have the disease. Until last week HIV was a lingering death sentence for most people diagnosed, and an overwhelming fear for those who became sick and did not test. I led a team from our Health Centre to Kampala for a week of training in February, and BCHC is now one of 50 HIV Treatment Centres in Uganda supported by Joint Clinical Research Centre (JCRC). This means that we get logistical support, some funding and most importantly a consistent supply of free antiretroviral drugs for those who need them and are unable to

pay. Every Tuesday we now have an HIV clinic with a queue of people wanting to be examined and treated. When the first consignment of drugs arrived via courier on Tuesday I felt a quiet pride. This is probably the most important thing that I've managed to accomplish in my career so far.

Today I'm off to an outreach at a Batwa Pygmy settlement. We now take family planning and antenatal services on this weekly trip, and will soon be vaccinating children there rather than just giving them weekly treatment for malaria. BCHC now has a Public Health Dental Officer, and we are transforming our dental services to put at least as much effort into prevention as to cure - Education not Extraction.

Paul's Fourth Update, August 2007

Malaria prevention work

Until recently Vicky and I dealt every week with children carried in fighting for their lives, with high fevers, seizing from the effects of the malaria parasite on the brain, and deathly pale from destruction of their red blood cells. But in the last few weeks we've stopped noticing the problem, and our supply of blood for transfusion has expired, largely unused. Our laboratory diagnosis rate of malaria has plummeted, and the supplies of anti-malarial drugs are so plentiful that we need a new store to keep them in! This is why...

In June I received a call from Edson, a doctor working at a Government Health Centre three hours walk from Bwindi. He told me that the Government had provided him with more than 3,000 mosquito nets for distribution to all pregnant women and children under the age of one, and he wanted my advice on how we could distribute them. We met together, and devised a plan that has been effective beyond our wildest dreams.

Edson arranged a meeting the next day between Godfrey (a Community Health worker at Bwindi Community Health Centre) and each of the Chiefs from the five Parishes that we serve (an area of about 28,000 people – not that large, but very difficult to negotiate due to terrible roads and mountainous terrain). They brought with them the Health Mobilisers from each Parish – individuals who volunteer their time to spread information about health matters. There is no Internet, no TV and only one radio station here, so the channels of communication are limited. In Uganda many people like this work for free, or for very little money. I used some of my budget to 'facilitate' these people to the tune of about £6 each.

Each Chief then went to their Parish and arranged a training day within the next week. Two representatives from each village were sent to attend the training day, to give them skills on how to educate their villagers about malaria. In total representatives from 61 villages attended. Each village health worker was then trained in the causes of malaria, how to prevent malaria, and how to care for bed nets. They were also taught how to teach this to their villagers, and were given some picture teaching aides painted on sacks that I had bought in Kampala. They returned with enough bed nets for everyone on their list, and an accountability form.

Each of the village health workers has been returning their accountability forms with a signature or thumbprint next to the name of each person (or parent) given a net.

We have raised enough money to buy other mosquito nets, and we keep them at the Health Centre to sell at heavily subsidised prices to anyone who wants them – including all of our patients with HIV, children over the age of one and pregnant women who slipped through the...er...net!

[See also p.5]

HIV prevention work

It is within our power to stop HIV in children. Almost all cases are transmitted from mother to child during pregnancy, delivery and through breastfeeding. We cannot tell people to stop breastfeeding – a child not breastfed is 20 times more likely to die than one who is – but our programme of Prevention of Mother to Child Transmission (PMTCT) is working. All women (and plenty of men) are offered HIV testing in our packed antenatal clinic, and those who test positive are put onto antiretroviral drugs throughout the rest of pregnancy, and for the duration of breastfeeding. Our midwives deliver all of the mothers in a safe way, and the babies are put onto drugs for the first week of their lives.

Now for the statistics: PMTCT reduces transmission from mother to child from 50% to less than 2%. We serve a population of 28,000 people, and 1,800 babies are born every year. The prevalence of HIV in pregnant women is 6%; so 108 babies will be born to HIV positive mothers. Without our interventions 54 of them would get HIV. With PMTCT only two will. So we can save a baby from HIV every week.

In the next year we will be taking our PMTCT to every parish in this area – giving every woman the chance to stop her child from getting HIV. A team will travel in the community and work at all of the other Health Centres who don't have access to test kits or drugs. Our dream is the elimination of HIV in children altogether.

Paul's Fifth Update, February 2008

The organisation that my partner Vicky and I joined has changed beyond recognition. Thirteen people (plus an army of overseas volunteers) have become forty Ugandans. Some of the new staff are superb and we have progressed well in the strategic planning that we've been doing. Malaria is now a rare disease, thanks to an immense prevention programme. Three thousand local people have been counselled for HIV and have been tested, and more than three hundred have tested positive. Hundreds of pregnant women come each month for maternity care. Health promotion takes place daily, and the treatment of sick patients is not the main function of the organisation.

In 2007 we tested more than 3000 people for HIV, including more than 900 pregnant women. We have taken mobile testing to all of the Batwa settlements in the area, and to the villages where HIV prevalence is highest. We sent ten staff members on HIV training courses in Kampala, enrolled two hundred and forty HIV positive people in the weekly HIV clinic, and started many of them on free antiretroviral drugs. We gave drugs to all pregnant women with HIV to stop mother-to-child transmission (PMTCT). We also started to sensitise the population about HIV & AIDS through visiting villages and through appearing on the radio to talk about prevention and treatment.

In 2008 we want to continue all of the sensitisation, testing and treatment that we have done in 2007 including testing every pregnant woman in the area for HIV in order to give all of

them drugs to prevent them giving the virus to their babies. We will do this by taking HIV testing and treatment for pregnant women into different parts of the area. We want to build an HIV clinic so that we are not operating the AIDS service out of one small room in the corner of the maternity unit.

We want to expand our successful treatment programme - we have a guaranteed free supply of drugs, and if we can fund a team including a doctor, clinical officer, two nurses and counsellors we want to be able to offer HIV services every day. If this happens we will start mobile HIV & AIDS clinics in other hospitals in the region who currently do not have access to treatment or who do not have trained staff. We intend to improve non-clinical services for people living with HIV & AIDS. We want to offer them all mosquito nets to prevent malaria, information about 'positive living' through a post-test club, and good access to condoms.

After finishing the construction of the new Children's Ward, we're ready to build an HIV and Women's health clinic this year, along with a new Maternity Ward and a hostel for waiting mothers – all projects that I've worked hard to interest donors in and will now be able to deliver. Our latest challenges are with drainage and power. For the drainage we need to dig a series of trenches and canals during the dry season to stop the site continually flooding when the rains begin again in February. For the power we have designed a system of solar panels, large batteries, inverters and a generator that will guarantee us power for the next twenty years. We have no electricity in Bwindi and want to open an operating theatre next July.