NEWSLETTER

August 2013 Issue

ACTS 1:7-8

"Transformed Lives through Christian Quality Health care"

UGANDA PROTESTANT MEDICAL BUREAU

UPMB Staff and COU bishops during the House of Bishops meeting

Inside This Issue

ACTS 1 : 7-8

A doctor's interesting Tale

By Gideon Kuriigamba
Bwindi Community Hospital-Kanungu

Heath workers at Bwindi hospital attending to a patient

Seeing patients as a doctor in the clinic or those admitted on the ward daily, you are struck by how often you have to find an answer or solution for every patient's problem.

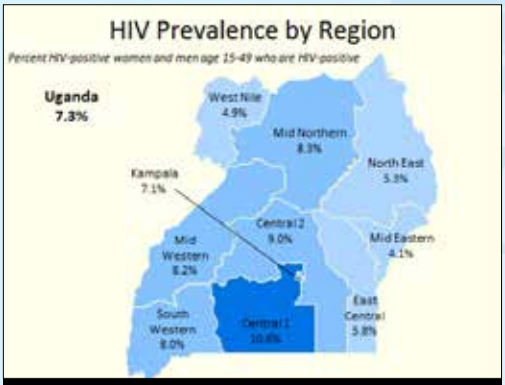
On a windy Thursday afternoon, while on a ward round, I found a 60 year old man called Paddy (not real names) in deep agonizing pain; his right leg was darkening progressively and was beginning to develop a foul smell! He had been a heavy smoker for the last 40 years and had a similar episode on his left leg one year ago which was amputated (cut off). As I looked at him closely, he had dry gangrene (death of his leg tissues) most likely from smoking (a condition called Buerger's Disease) yet, with this pungent smell and oozing discharge, I said, "Gosh, this is turning into wet gangrene (where there is invasion of the tissues by dangerous species of bacteria), that will infect the whole body in a matter of hours and kill the patient."

With no facilities to ascertain the integrity of blood vessels (venography/arteriography) to make an accurate diagnosis, this uncertainty was, compounded by the patient's inability to afford a referral to the next hospital. The decision was made to give him „strong" antibiotics and rush him to the operating room to amputate him in order to save his life.

Our goal was to slice through normal muscle tissue, just centimeters above the gangrene, and break two bones. There was no chain saw, normally used for amputations - Instead, we improvised by using a drill and removed the infected limb, washed him with saline, and then sealed his wound.

When he woke up the next morning after recovering from the anesthesia, he could not believe, that the tremendous pain he had withstood was gone. He is currently recovering in the ward, adapting to the life with no legs, but in much less pain. It is with your generous support that we are able to maintain such a team of good doctors, nurses, anesthetists who work even with the meager re-sources to make a difference in people's lives.

Addressing the leading factors in the increased infection incidences is key in reversing HIV/ AIDS trend in Uganda.



Source: Uganda AIDS Indicator survey 2011

During the world AIDS day celebrations in December last year, President Museveni pointed out that adultery and prostitution are the leading factors in the increased infection incidences, also citing the practice of multiple sexual partners which is more pronounced among men today as contributory factors to the increased infection incidences.He also called upon health workers and organizations engaged in fighting HIV/AIDS to sensitize Ugandans on the real health benefits of circumcision in order to avoid giving a false sense of security that circumcision is an immunity booster……..continued on page 3

Marburg Epidemic experience in Uganda -Rugarama Hospital

By Dr. Gilbert A. Mateeka and Dr. Aaron Morrow
Rugarama Hospital

In the month of October 2012, Health care workers and local residents in Kabale were faced with the challenge of a Marburg virus outbreak. Since all the first cases had been attended to at Rugarama Hospital, the Hospital was at the Centre of the Epidemic.

Marburg is a virus that can be transmitted to humans from contact with infected animals or contact with humans that have subsequently become infected. It is thought that the virus reservoir is in bats, but other animals can also become infected. Marburg virus is named after the German town where the first outbreak was noted after a number of industrial plant employees were infected following contact with monkeys from Uganda. Marburg causes a hemorrhagic fever similar to Ebola.

Marburg is spread from person to person primarily through contact with bodily fluids including saliva, blood, sweat, etc. There is no specific treatment or antidote for those infected. Treatment consists of supportive care with the hope that the patient is able to survive and overcome the infection. Prior outbreaks in Africa have had mortality rates 80-90%.

While it is not known how the initial victim contracted the illness, he presented to Rugarama Hospital in mid-September with non-specific symptoms that did not initially suggest the cause. At first, the most worrisome symptoms pointed towards an abdominal condition that required surgical review. The patient was referred to Kabale Regional Referral Hospital but died within a few days after referral.

Within a few weeks, two additional family members began seeking medical care for non-specific symptoms such as fever, headache, muscle and joint pains. This included the initial victim's mother, who died shortly after admission. Her son was also admitted but sought transfer to Kampala for further care where he gradually recovered.

A week after this, his brother and sister who had been attending to him became sick, and they were admitted to the Regional Referral hospital where they died. Upon admission there was suspicion of the possibility of an outbreak and their blood samples were taken for further analysis including that of their recovering brother in Kampala. The results from all 3 were positive for Marburg; however, the 2 died before the results were known. Another family member, who had traveled to Kampala, became sick and had a miscarriage. She, like the others was positive for the virus. She received care at Mulago Hospital and recovered. Nonetheless, from this index family, 5 deaths occurred.

It was later discovered that a mortuary attendant who had cared for the body of the 1st victim had died. At the time of the confirmation of the epidemic, the mortuary attendant's mother, wife, and sister were admitted at the Referral hospital. They were immediately taken to an isolation ward, and blood tests confirmed that they all had the virus. The mother ultimately did not survive, but the wife and sister recovered.

Another woman became infected after praying and laying hands on one of the earlier victims. Her contact with the victim came prior to the knowledge of the Marburg threat (many members of the index family had sought prayer from members in the community for healing). After becoming symptomatic, the woman's blood tests were found to be positive for Marburg. Her nursing baby likewise was positive for the disease. Fortunately, both mother and child recovered successfully. By Ugandan standards, the response to the epidemic by the ministry of health and development partners was quick and effec-

tive. An isolation area was established and efforts were made to identify and treat cases, as well as educate the local population about the disease. Some local health care workers also volunteered in the effort to combat the outbreak. In the following weeks, much time was spent identifying potential contacts of known victims, which included health care workers that had treated victims, family members that had cared for the infected and others that had attended burials.

Contacts were indirectly followed over a 10 day period in order to see if symptoms developed. At the same time, new cases such as the ones listed above were being identified and brought to the isolation center. In total there were 13 infections, 7 deaths, and 6 survivors. A total of 204 contacts were being followed up daily at the beginning of the response.

Through it all, some sections of the community (including members of the index family) still hold that there was no Marburg threat at all. This is because the index family was polygamous with sour relationships between the co-wives and a strong belief in witchcraft.

This background affected the perception of the epidemic from start to finish.

However, efforts to identify and track contacts, isolate victims, and educate the local population were not in vain, as subsequently there were no new cases.

On Wednesday 3rd January 2013, the Minister of health Hon. Christine Ondoa declared the end of the Marburg Epidemic in Kabale and closed the isolation Centre. As part of this activity, she visited Rugarama Hospital and appreciated the High level of infection control that prevented any chance of Hospital amplification of the Marburg epidemic, which is commonly seen in other similar epidemics.

Throughout the epidemic, it was living a day at time and hoping that what you are feeling is not a sign or symptom of the infection and that the patient that you have just seen was not a suspect. Ultimately, On 23rd December 2012, Rugarama Hospital staff, Management and Board Members came together to Thank God at St. Peter's Cathedral for protecting them from Marburg Virus, were the hospital management and staff saw Psalm 91 come to pass.

In addition, Rugarama hospital takes this opportunity to thank the lord for provision of a 45Million worth X-ray Machine. Our appreciations go to St. Andrew Blackadder Church of Scotland, Friends and Churches in the US and UK who allowed God to use them in this noble cause.

The Diocesan Secretary – Kigezi, officially opens the X-Ray unit

The Diocesan treasurer (Kigezi) dedicates the New X-ray machine

Addressing the leading factors in the increased infection incidences.

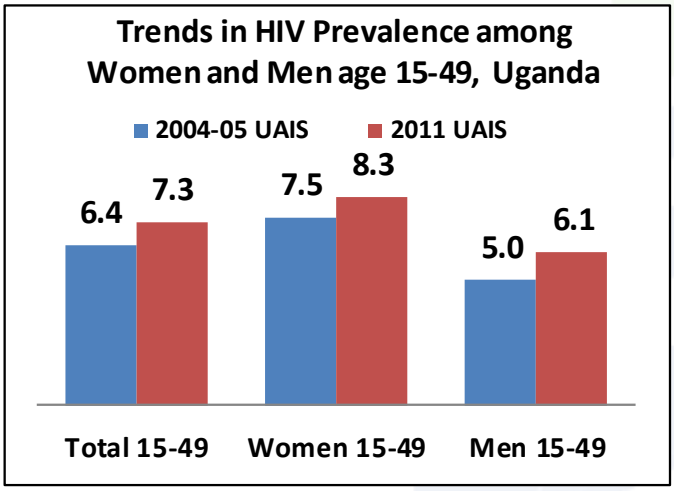
.....Continued from page 1

against HIV/AIDS. According to the Uganda AIDS Indicator Survey (UAIS) conducted in 2011, results indicate that 7.3% of adults aged 15-49 in Uganda are living with HIV. Among children under age five, HIV prevalence is 0.6%. These results are based on a nationwide survey that was conducted to provide estimates of HIV prevalence and other important HIV/AIDS programme indicators. These results demonstrate indisputably that HIV/AIDS remains a significant health problem for Uganda and should serve as a call to action for all Ugandans. The Ministry of Health along with other dedicated international partners took this as an opportunity to recommit themselves to continued scale-up of proven HIV prevention interventions, universal access to ARV treatment, and to the shared vision of a future free of HIV.

The Uganda AIDS Indicator Survey results indicate that the proportion of adults with HIV has increased slightly since the last national population-based survey in 2004-05. HIV prevalence is higher among women (8.3%) than men (6.1%). In addition, HIV prevalence increases with age until it peaks at age 35-39 for women (12%) and at age 40-44 for men (11%). Four percent of young adults age 15-24 are living with HIV.

Women in urban areas have a higher HIV prevalence than those in rural areas (11% versus 8%); there is no urban-rural difference in HIV infection among men (6.1%, each).

HIV prevalence is highest among widowed women and men (32.4% and 31.4%, respectively) and lowest among women and men who have never been married (3.9% and 2.0%). HIV prevalence varies by region, from a low of 4.1% in Mid-eastern region to 10.6% in Central Region. The survey shows that there has been a tremendous increase in voluntary HIV testing in Uganda over the past 6 to 7 years. The proportion of women age 15-49 who have ever been tested for HIV and received their results increased fivefold, from 13 percent in 2004-05 to 66 percent in 2011.



The Uganda AIDS Indicator Survey results demonstrate both the strengths and challenges of Uganda's HIV response. The survey identifies a continued need for individual behavior change, and scale-up of evidence-based prevention interventions such as prevention of mother-to-child transmission services and safe male circumcision, as well as increased treatment coverage for people living with HIV. Interventions should be targeted to those most-at-risk populations and must pay particular attention to those regions and districts most heavily impacted by the epidemic.

Tales of our field experiences! Kamwenge

By Dr. Kenneth Kabali
Quality Assurance Officer - UPMB

Many times we plan thoroughly for field work, put in concept notes, present itineraries, then a requisition and get travel authorization but what we don't plan for are any other eventualities. Well, save for the emergency fund in the budget. Not so long ago, we planned to do our accreditation exercise

for most of our HCIIIs country wide, to start providing ARVs especially for mothers who turn out HIV+. On this particular occasion we were in the west. Some of you who have travelled this side of the country and know the long dredge of dust that sweeps the long and bumpy ride on Kamwenge road off Fort portal city town. Something has caught on with our field officers, where on any day, you have got to brace yourself for the worst, like a whole day without food! That early morning of 24th January 2013 we had the usual 'Nkokokoto' (read concrete-an assortment of Katogo, Chapati and milk tea). Happily done with the usual, we hit the road to the furthest ends of Kamwenge reaching Kabuga COU HC III. We were impressed by the number of patients there. This HC III is in one of the newly formed dioceses -East Rwenzori, a break away from Ruwenzori and is indeed very active (see for yourselves).

Of course there is a lot of learning each time you are in a new district. Here in Kamwenge you will

A que of Clients at Kabuga church of Uganda HCIII

UPMB Executive Director & quality assurance officer recieving a severely convulsing eclamptic patient from the Ambulance

find a fine blend of our brothers from the mountains of the moon-the Kiga and Bafumbira and only catch a tiny glimpse of the Batooro in their own 'would be' land. At the facility it seemed like a mother delivered every couple of hours and we reckon it is just the right place to have Option B+ entry point for comprehensive HIV care. In fact we wished Kabuga had been given the privilege of sharing in the benefits of the Maternal and Neonatal (MNH) project but Alas! It's only ending. Having left Kabuga, we hit the dusty roads again, we were secure from direct effects as our Prado conditioner funs not only cooled its engine but extended tous a semblance breath of fresh air.

Half way between Kamwenge town and Kyabenda COU HC III-our next destination, a 4WD ambulance sped past us with a deafening siren. We had absolutely no idea what it was all about except that may be our best guess the ambulance was headed for Kabarole hospital. Shortly after, we were amazed to find it at Kyabenda HC III. Dr. Tonny and I came in handy! There was this convulsing severely eclamptic patient with her pressures through the roof and had become unconscious.

We rolled our sleeves in a heartbeat as your instincts would tell you and charged up to do the work.

Fortunately the ambulance had carried some Injectable Magnesium Sulphate from Kamwenge HC IV where the doctor had gone AWOL (absent without official leave), which we administered as a slow bolus. We stuck around for a few, and the patient slowly regained consciousness and lowered BPs before we advised to have the patient be pushed further to hospital for a maintenance dose. It was indeed a stitch in time. We want to applaud the staffs at Kyabenda together with the Baylor ambulance for a job well done! A

Bwindi hospital to start a nursing school

BWINDI NURSING SCHOOL IS HERE

The Rt. Rev. Dan Zoreka breaks the ground at the Nursing School during the ground breaking

mother's life was saved that day. I am reminded, big up for the SMGL-Saving Mothers Giving Life project, its life should live on and perhaps save freelance doctors a pay cheque. If only the district can monitor closely the presence of doctors wherever they are posted, we would not see a top down referral (HCIV - HCIII) as was the case. Your average day in the field is challengingly thrilling. Just remember to have a heavy meal to start your day always. Life never tells us what happens next.

Bwindi Community hospital is excited to report that they have begun to construct the Bwindi School of Nursing. The ground breaking ceremony took place on 4th September, and was officiated by the Bishop of Kinkiizi diocese who is also the Chairman Board of Governors, Bwindi Community Hospital; District officials, including the Resident District Commissioner and other dignitaries. Platinum Engineering Limited will be undertaking the first phase of construction to be completed by August 2013 to allow for the first students intake in November of the same year. Bwindi School of Nursing will be affiliated to Uganda Christian University and graduates will receive diplomas of UCU. Students will have a unique opportunity of blended e-learning from Texas Women's University to acquire advanced training and accreditation equivalent to that of a Registered Nurse. Through this program, Bwindi Community Hospital hopes to create a reliable and sustainable base of highly qualified health professionals capable of improving health in local communities and the region. The initial class size in this three year Program will be 24 students and will increase annually, until a total student population of 72 has been attained. It is in-tended that in future, the school will double its capacity and expand to 144 students. Bwindi Community hospital is grateful to Stephen Wolf and James Jameson for the great support.

BWINDI HOSPITAL LAUNCHES COMMUNITY MENTAL HEALTH SERVICES

Statistics show that close to 20% (6.8 million) of the 34 million people in Uganda have some forms of mental illness, ranging from anxiety and depression to severe madness. Bwindi community hospital is happy to report that beginning September this year; the Hospital will start offering specialist mental health care in collaboration with Kabale Regional Referral Hospital.

"Our clients will have an opportunity to be reviewed by the only psychiatrist in the region" - Dr. Kabega Jacinta. The clinic will initially run every last Thursday of the month and then clients will be followed up by our community health team that will include a psychiatric, clinical officer and a medical social worker.

UPMB ROLLS OUT CHARTER FOR LLUs

By David Kiyimba
Institutional Capacity Building Officer

The ICB Officer (squatting left) and In-charges of facilities in Kinkinzi Diocese during the roll out of the LLU charter in the diocese

UPMB rolled out the charter for member lower level facilities (HC IIIs & IIs) during the technical support visits to lower level facilities in Kigezi, Kinkiizi and Ruwenzori Dioceses in Western Uganda. The purpose of the charter is to:

- Provide the basis for defining the minimum health care and management standards required to join and identify with the UPMB network.
- To provide the basis for monitoring performance of the member health units in regard to the set standards through continuous feedback and improvement.

The areas covered by the charter include; name and identity of the health facility, ownership, mission, vision and goal of the health center, health policy and guiding principles, wholistic approach to health care, equity and sustainability, integration in the national and district health system, professionalism, quality care and training, governance and accountability, management of financial and material resources and daily implementation of the charter are some of the other themes covered.

The lower level facilities will be required to submit to UPMB copies of the charters signed by relevant authorities as a sign of commitment to implementation of sections stipulated there-in, to join and identify with the UPMB network. The technical support visits to lower level facilities shall continue through the first half of 2013 to other Dioceses.

UPMB ROLLS OUT HUMAN RESOURCE GUIDELINES FOR MEMBER FACILITIES

By David Kiyimba
Institutional Capacity Building Officer - UPMB

Human Resources management is a key component of quality health care provision in UPMB member health facilities. However, for such a long time, many of UPMB member health facilities have lacked clearly documented policies for managing their human resources. The situation was not helped by the lack of documents at the Secretariat to guide the development of such policies and institutionalization of the same. This financial year, UPMB rolled out the documents to guide legal owners of member health facilities to develop policies using the guidelines.

The guidelines for Hospitals, HCIVs and lower level facilities (HC IIIs & IIs) are accessible and can be downloaded from the UPMB website www.upmb.co.ug in the Documents section.

MENGO HOSPITAL

SCHOOL OF NURSING AND MIDWIFERY

By Mercyce Mutyaba, Principal Tutor
Mengo School of Nursing and Midwifery

Mengo School of Nursing and Midwifery - "Centre of excellence"

Mengo School of Nursing and Midwifery is the oldest training School in Uganda. It was the first school for Nursing and Midwifery in Uganda and East Africa as a whole and is known as the heart of medicine in Uganda. It is private, not for profit school under Church of Uganda.

The school was founded by Mrs. Catherine Cook who started training 8 Enrolled Midwives in 1917 and qualified in 1919. Enrolled Nursing was started in 1928 and qualified in 1930, Registered Midwifery in 1976, Registered Nursing in 1979 and later Enrolled Comprehensive Nursing in 2006 November.

Students at the Nursing school

Objectives

1. To produce market relevant nurses with a broad field of knowledge and competent in the required skills.
2. Enable students to appreciate the contribution of other health workers/ personnel in total patient care environment.
3. Help them develop leadership skills and being exemplary in service Health Care service delivery.
4. Help students to develop a sense of professional career, principled and ethical in the day to day practice.

Courses offered at the school

1. Registered Nursing and Midwifery [Diploma] 18 months [Extension course]
2. Enrolled Comprehensive Nursing [Certificate] 2 ½ years
3. Enrolled Nursing and Midwifery [Certificate] 2 ½ years.

A. Registered Nursing and Mid Wifery

''O'' level certificate
Professional certificate

Mengo School of Nursing and Midwifery - "Centre of excellence"

The course is for both males and females except midwifery course where females only apply.

Applicants should have worked for at least 2 years

Documentation to be submitted

- *Handwritten application*
- *Copies of academic results*
- *Professional results*
- *Letter of recommendation from the employer, Religious leader of the area, LC 1 Chairman.*

B. Enrolled Nursing/Midwifery/ Comprehensive Nursing

- *''O" level Certificate with 5 passes in Biology, English, Mathematics, Chemistry and Physics*
- *Other requirements:*
- *Must not have been out of school for more than three years.*
- *The course is for both male and female.*
- *Handwritten application*
- *Copies of the identity cards of the former schools.*
- *Copies of academic results – ''O" and ''A"" level pass slips and certificates.*
- *Recommendation from the previous school*

Contacts:
P.O. Box 7161 Kampala
Tel.: +256-414-274869, +256-414-270222/3
Email: merycemutyaba@yahoo.com

INSPIRATION TO ALWAYS HAVE 'THAT OTHER ROUTE'

By Jonathan Miyonga
Monitoring and Evaluation Officer -UPMB

A pretty woman was serving a life sentence in prison. Angry and resentful about her situation, she had decided that she would rather die than to live another year in prison. Over the years she had become good friends with one of the prison caretakers. His job, among others, was to bury those prisoners who died in a graveyard just outside the prison walls. When a prisoner died, the caretaker rang a bell, which was heard by everyone. The caretaker then got the body and put it in a casket. Next, he entered his office to fill out the death certificate before returning to the casket to nail the lid shut. Finally, he put the casket on a wagon to take it to the graveyard and bury it.

Knowing this routine, the woman devised an escape plan and shared it with the caretaker. The next time the bell rang, the woman would leave her cell and sneak into the dark room where the coffins were kept. She would slip into the coffin with the dead body while the caretaker was filling out the death certificate. When the care-taker returned, he would nail the lid shut and take the coffin outside the prison with the woman in the coffin along with the dead body. He would then bury the coffin. The woman knew there would be enough air for her to breathe until later in the evening when the caretaker would return to the graveyard under the cover of darkness, dig up the coffin, open it, and set her free.

The caretaker was reluctant to go along with this plan, but since he and the woman had become good friends over the years, he agreed to do it. The woman waited several weeks before someone in the prison died. She was asleep in her cell when she heard the death bell ring. She got up and slowly walked down the hallway. She was nearly caught a couple of times. Her heart was beating fast. She opened the door to the darkened room where the coffins were kept. Quietly in the dark, she found the coffin that contained the dead body, carefully climbed into the coffin and pulled the lid shut to wait for the caretaker to come and nail the lid shut. Soon she heard footsteps and the pounding of the hammer and nails.

Even though she was very uncomfortable in the coffin with the dead body, she knew that with each nail she was one step closer to freedom. The coffin was lifted onto the wagon and taken outside to the graveyard. She could feel the coffin being lowered into the ground. She didn't make a sound as the coffin hit the bottom of the grave with a thud. Finally she heard the dirt dropping onto the top of the wooden coffin, and she knew that it was only a matter of time until she would be free at last. After several minutes of absolute silence, she began to laugh. She was free!

She was free! Feeling curious, she decided to light a match to find out the identity of the dead prisoner beside her. To her horror, she discovered that she was lying next to the dead caretaker. Many people believe they have life all figured out..... but sometimes it just doesn't turn out the way they planned it. Think of a 'Plan B'

UPMB PARTICIPATES IN THE UGANDA ROTARY'S 3RD-ANNUAL "ROTARY FAMILY HEALTH DAYS" (RFHD).

By Dr. Kenneth Kabali
Quality Assurance Officer

Uganda Rotary held its 3rd-annual "Rotary Family Health Days" (RFHD) between 9th and 11th May 2013, where over 60 Rotary Clubs across Uganda were expected to support coordinate and provide free health services in approximately 140 locations to over 120,000 people. CDC-Uganda, was proud to partner with Rotary to make this event a success—and needed its Implementing partner's participation in the activity. Within these dates, (7th – 11 May 2013), UPMB had pre-organized an SMC camp at Ngora hospital which coincided with the Rotary Family Health Days (May 9th -11th, 2013). The target for HCT and SMC was set at 700 men and 1000 individuals screened for hypertension, Malaria, Diabetes, immunization and family planning services for RFHD.

The objectives of the Rotary Family Health Days (RHFD) and the SMC camp were to increase progress towards UPMB's SMC target, enhance the capacity of the health facilities to conduct SMC camps, contribute to national expansion of SMC services and screen individuals for Hypertension, Malaria, Diabetes, Immunization and Family planning services for RFHD.

A health worker counseling a client during the RFHD.

A lab technologist does RBS to screen those with diabetes

Key achievements

Rotary Family Health Days

Rotary family health days were a success. Ngora received an overwhelming number of people in need of screening for hypertension, advice and uptake of family planning services, screening and treatment of Malaria with ACTs, screening for diabetes with use of gluco-sticks for random blood sugar (RBS), Immunization and condom distribution. Close to 150 patients were seen on each of the 3 days.

Safe Male Circumcision

In five days of hard work, 60% (414/700) of expected target was achieved. However, two implementing partners, UPMB and Baylor were holding camps in close proximity, mobilization efforts were reinforced using a public address system after efforts to find a mega phone were futile.

UPMB MNH project demonstrates low cost interventions in "Closing the Gaps" in maternal and child health

By Jonathan Miyonga
Monitoring and Evaluation Officer-UPMB

UPMB with support from National Lottery Fund through Interact World Wide has been implementing the Maternal and Neonatal Health Project "Closing the Gaps" under UPMB's Program area 5 of Reproductive Health and HIV/AIDS. The 4 year (2009-2013) project that closed in March 2013 aimed at accelerating and improving maternal and neonatal health services in poor marginalized communities.

The project targeted the poor rural and marginalized women, girls, and newborn, Women in reproductive age who are not accessing maternal and neonatal health (MNH) services such as family planning (FP), HIV counseling and testing (HCT), prevention of mother to child HIV transmission (PMTCT), antenatal care (ANC) and other services, facility health workers and community based service providers such as the community based volunteers (CBVs), village health teams (VHTs) and traditional birth attendants (TBAs), stakeholders, including health facilities, Ministry of Health (MOH) officials, District Health Officers, Local Council Chairpersons, District Chief Administrative Officers, political leaders at all levels, and other MNH organizations collaborating with UPMB and decision makers at community level, such as Local councils, women representatives, Religious leaders, and CBVs.

The project has been implemented in 21 districts and 30 Health Facilities.

Achievement of Outcomes.

Outcome 1: Reduction in maternal and neo-natal deaths and morbidity through increasing skilled attendance at birth.

By the time of the evaluation, the project had achieved 86% of the target for this outcome. The achievements for Year 1 fell below the targets, probably because the project was still in the establishment phase. This improved in Years 2 and 3, with the number of births attended by skilled workers increasing from 12,089 in Year 1 to 15,738 in Year 2 and to 17,808 in Year 3. The achievement for Year 4 was at 59% with data for only the last month of the year not included, which meant that the target for this

year was unlikely to be met. Overall however, the results for skilled attendance at birth show an upward trend over the years. Qualitative data collected from both community members and health facility staff indicate that maternal deaths during labor and delivery were noticed to have reduced, partly attributed to more mothers seeking skilled assistance during delivery.

Outcome 2: Improved quality and increased coverage of maternal and new born health services including essential, basic emergency and comprehensive emergency obstetric care.

The project achievement for this outcome was at 78% of the target. There has been an increasing trend in the provision of MNH services over the first, second and third years. Nevertheless, results for Year 2 and 3 fall short of the target, and Year 4 was at 57% with only one month remaining to the end of the last project year. These shortfalls were partly attributed to shortages in staff (including turn-over of health workers) stock outs of essential supplies, and sometimes inadequate resources to run outreaches. Assessments of the quality of services by clients interviewed at the health facilities indicated that clients were overall highly satisfied with the quality of services provided.

Outcome 3: Improved maternal and neonatal health in selected communities, by increasing number of pregnant women and girls receiving ANC and PMTCT+

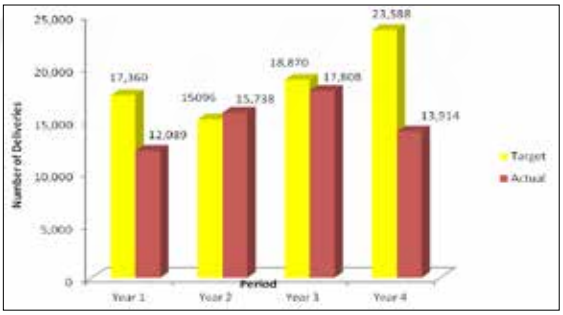
The project achieved a steady rise over the first three years in the number of mothers attending ANC for the first time during a given pregnancy, with achievements exceeding the target at 103%. Similarly, the project realized a positive trend in the number of mothers attending ANC for the 4th visit or more, although the achievement for this indicator was only at 40%. Thus, a big discrepancy remains between the number of 1st ANC and 4th ANC visit attendees, the latter being much fewer. This is a broader problem affecting the whole country, which the project partly sought to address.

With respect to PMTCT, the project performed well and surpassed its targets for enrolling HIV positive mothers into the programme at 102%. Increased enrolment of HIV positive mothers into PMTCT was enabled by the availability of HIV Testing kits as well as medicines for supporting HIV positive mothers. Others also reported stock outs of septrin. These concerns were also echoed by service users.

Outcome 4: Dissemination and replication of best practice project models resulting in increased capacity of implementing partners, other NGOs in the sector and Government service providers to deliver quality MNH services in each of the focus countries by the end of the programs (MNH).

With respect to this outcome, project staff participated in three all-partners' meetings each taking place in each of the respective countries, where lessons and experiences were shared. Three UPMB Annual Review meetings were held and lessons shared between IPs. Project staff also participated in two symposia organized internationally, and some forums organized nationally. The project staff also shared experiences at Ministry of Health-MCH Cluster meetings. The project organized an advocacy capacity building workshop for UPMB staff and a documentation and learning write shop for all the Partners but these came late in Y4 Q2 and Q3 respectively. Project successes were documented in the UPMB newsletter that focused on MNH, including some case stories. Not much documentation was done beyond this. A key challenge faced was lack of skills to identify what to document and to undertake the documentation.

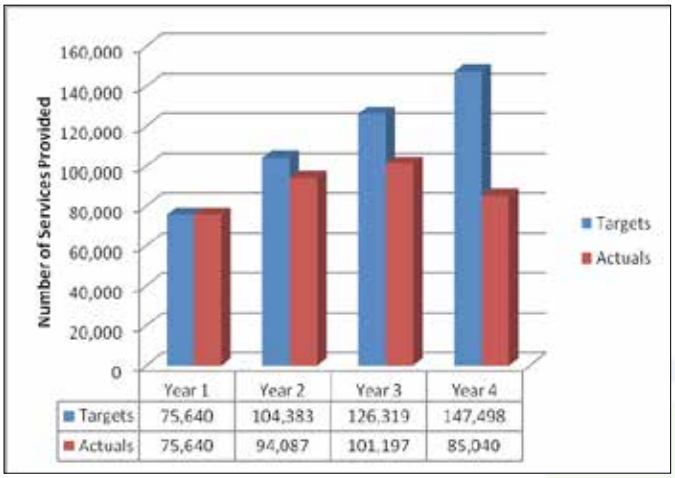
Outcome 1: Increased Skilled Attendance at Birth Number of Deliveries attended by Skilled Health Workers Year 1 to Year4



It can be observed that the achievements for Year 1 fell well below the targets, probably because the project was still in the establishment phase. This improved in Years 2 and 3, following the revision of targets downwards, but also improved performance that saw the number of births attended by skilled workers increasing from 12,089 in Year 1 to 15,738 in Year 2 and to 17,808 in Year 3. The achievement for Year 4 (with only the data for March 2013 not included) is at about 59%, which means that the target is unlikely to be met.

Outcome 2: Improved Quality and Coverage of MNH Services

Number of Service "Hits" Provided



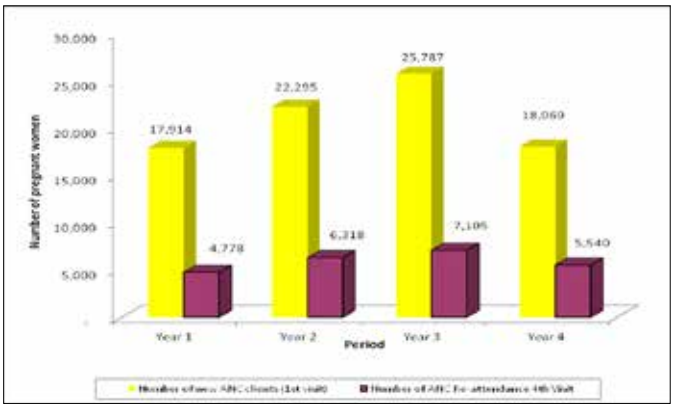
	Year 1	Year 2	Year 3	Year 4
Targets	75,640	104,383	126,319	147,498
Actuals	75,640	94,087	101,197	85,040

Service hits Include ANC new & re-attendances up to 4 visits, Deliveries, PNC, Post Abortion care (PAC), family planning, Neonatal care etc. The data in the above figure show an increasing trend in the provision of MNH services over the first, second and third years. Nevertheless, results for Year 2 and 3 fall short of the target. Achievement for Year 4 is also at about 57% of the target with only data for one month not included. The short-falls in achieving targets was partly attributed to shortages in staff (including turn-over of health workers), stock outs of essential supplies, and sometimes inadequate resources to run outreaches.

Outcome 3: Increased ANC Attendance and PMTCT Enrolment

Utilization of antenatal health services is associated with improved maternal and neonatal health outcomes. Attendance of antenatal services is essential to ensuring a safe pregnancy. The project promoted ANC attendance amongst community members, with a focus on 4 ANC visits. Mothers who attended ANC were also introduced to other services, including STI treatment, HCT, family planning and PMTCT for those who were found to be HIV positive. The figure below shows the project's achievements with respect to ANC 1 and ANC4 attendance.

ANC1 and ANC4 Attendance Year 1 to Year 4

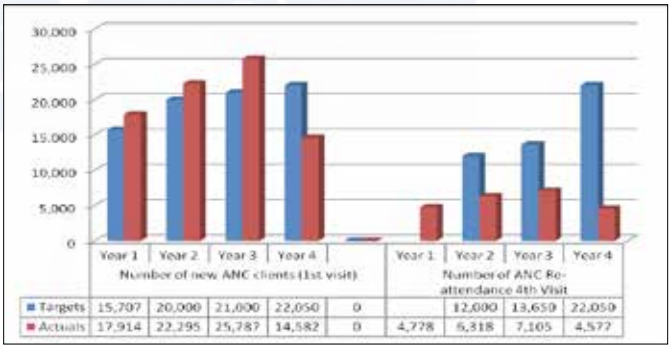


The project achieved a steady rise over the first three years in the number of mothers attending ANC for the first time during a given pregnancy. Similarly, the project realized a positive trend in the number of mothers attending ANC for the 4th visit or more. This was a good achievement indeed.

Comparison of Targets and Actual Achievements in ANC1 and ANC4 Attendance

A big discrepancy remains between the number of 1st ANC and 4th ANC visit attendees (see Figures 4 and 5). This is a broader problem affecting the whole country, which the project partly sought to address.

Comparison of Targets and Actual Achievements in ANC1 and ANC4 Attendance

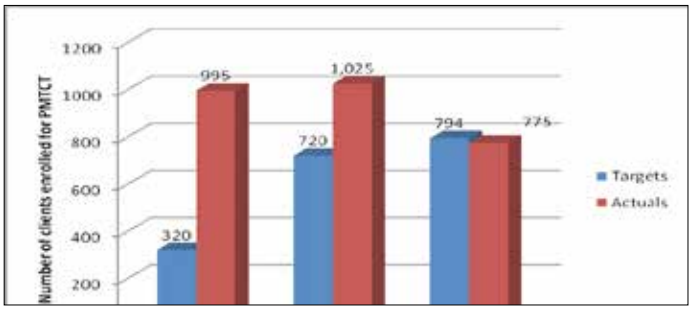


Interestingly, it can also be observed that the number of deliveries in the health facility (see

Figure 1) is higher than ANC 4th visit, and is closer to ANC 1st visit, although it still falls short of the ANC 1 level. Nevertheless, the results show that many more mothers come for delivery at the health facilities when they did not attend all the recommended 4 ANC visits. The high number of mothers attracted to deliver in the health facility was partly attributed to the provision of free mama kits, nets and voucher scheme which offset some of the cost barriers that stop mothers from coming to deliver in the facilities

.

Comparison of Targets and Actual Achievements for Number of HIV+ Mothers Enrolled for PMCTC



Increased enrolment of HIV positive mothers into PMTCT was enabled by the availability of HIV testing kits as well as medicines for supporting HIV positive mothers.

Outcome 4: Dissemination and Replication of Best Practice Models

With respect to this outcome, project staff participated in three all-partners' meetings each taking place in each of the respective countries, where lessons and experiences were shared. Three UPMB Annual Review meetings were held and lessons shared between IPs. Project staff also participated in two symposia organized internationally, and some forums organized nationally. The project staff also shared experiences at MoH-MCH Cluster meetings.

The project organized an advocacy capacity building workshop for UPMB staff in Y4Q2 and a documentation and learning write-shop in Y4Q3 for all the Partners. The project team participated in a three-country documentation and learning training where an action plan was developed.

Project successes were documented in the UPMB newsletter that focused on MNH, including some case stories. Not much documentation was done beyond this. A key challenge faced was lack of skills to identify what to document and to undertake the documentation.

In terms of replication, it was reported that the Community Dialogue approach had been adopted by one organization in Lira District, learning from UPMB's work. Overall, the discussion of the achievement of the four outcomes above indicates that the project has made tremendous achievements. The outcome for which there is the greatest achievement is outcome three, especially on aspects of ANC1 and enrolment of HIV positive mothers into PMTCT.

As discussed the key constraints to full achievement of outcomes were both contextual as well as logistical.

CASE STORIES

Case Story 1: If it were not the medical staff at Kiwoko Hospital, I would have died.

"In February 2012, I was pregnant and about to deliver so I went to Kakoge Health Centre. The nurse examined me and told me that am going to deliver at 1pm. She examined me again and said I was about to deliver. She examined the third time and she advised me to quickly get a vehicle and rush to the hospital that my baby was in a sitting position in the womb and that it was going to be a C-section. This scared me. When I arrived at Kiwoko, they gave me top quality care. They used machines while I was tied and the machines managed to set the baby into the right birth position, head first. They said that if I don't deliver at 6pm, they were going to do a C-section but at 5.30pm, I delivered. They kept looking at their watches until they told me to push the baby out. If it was not the medical team at Kiwoko, I would be a dead woman now since the baby was going to kick my heart and I die" (Mother, Kamuli Village, Nakaseke District).

Case story 2: Joselyn chooses to seek early ANC: Joselyn (not real name) is 28 years old and has come for ANC at Rwesande HCIV.

This is her seventh pregnancy and her fifth time to come here for ANC. "I decided to come here for ANC because they normally teach us that once you are three months pregnant you have to come here and they examine you such that they can know how the baby is … One also needs to attend ANC to know how one can handle herself in case she is HIV positive such that she cannot pass it to baby. I decided to begin ANC when I was three months pregnant, even now am still continuing". Asked who made decision for her to come to this facility, Joselyne replies: "I am the one who decided to come to this health center because the nurses teach us that we must start the ANC early. I decided to come here because this health facility has well experienced and caring nurses and doctors. Drugs are also always available at any time. The nurses here also handle us very well even if you come when you are dirty …" Asked if she got the services she had come for, she replies: "I have got the services I came for and even now am going back to do my domestic activities because there are some places you go to and spend the whole day in a line which is not the case here. I had gone four times somewhere else but they had not given me a mama kit but here I have got one".

Case Story 3: Rwesande PMTCT/Family Support Group

The group started about 3 years ago at the time of this evaluation, the group had 47 members, 20 females 27 men. "The group was started in order to support HIV positive people to have a positive mind. When we came for ANC, we found out that we were HIV positive. We self-organized and started this group to support each other", says another. "We offer support to each other, together as a group we feel relieved, we feel together and also support others. We get medication from this health centre which is nearer than where we used to go to get medication. We also receive care from the health centre, counselling and some food, we have lives that have been saved by this group. We have been able to bring our children and spouses for treatment and we now talk to others and bring them for testing and to start treatment. This child of mine also is negative thanks to being in the PMTCT group (showing off her 1 ½ year old child). Now at home there is peace due to openness between spouses about their HIV status. We used to be neglected as finished people but now we are accepted in society and we talk to other members". The group engages in savings and credit, and members' trade in locally available food stuffs to get some income. "We have savings which we can borrow from to send children back to school". They also have a nutrition aspect in which they buy food for nutritional supplements.

Asked why they have succeeded, the members have the following to say: "When we see ourselves healthy, then we have a reason to stick together. We have become a family, we love and support each other.
We were encouraged to make wills. We receive counselling every time we come to the facility and this helps us to calm conflicts between members".

CURE CHILDREN'S HOSPITAL EXTENDS SERVICES TO MORE UGANDANS

By Johnson Derek, Medical Director
CURE Children's hospital

CURE Children's Hospital of Uganda opened in January 2001 to specifically meet the needs of children living with disabilities. The hospital is a pediatric neurosurgical center focused on children with hydrocephalus, Spina bifida and other neural tube defects. To date, we have treated more than 45,000 children and provided over 11,000 surgeries for children living with disabilities. We have trained more than 250 healthcare professionals and 21 surgeons from our hydrocephalus fellowship program. CURE Uganda is leading the way in the treatment of hydrocephalus, the management of conditions like Spina bifida, and the support families and community members need in order to best care for their children.

CURE Uganda has become famous for its groundbreaking treatment of hydrocephalus using an endoscopic approach (ETV-CPC), which does not require the placement of a shunt, a liability for people living in areas where access to medical services is problematic. More than 75% of our patients are eligible candidates for this procedure. Numerous peer reviewed publications highlight the effectiveness of the ETV approach, as well as the cost benefits. For the majority of our patients, this is a one-time surgery and less invasive than shunt placement.

In addition to neurosurgical interventions for children, we also focus on long-term outcomes through the education of patient's parents, including how to provide therapy at home and how to manage their children's conditions. Our team of social workers educates parents about the rights of children with disabilities, as well as training on how to advocate for their children, and how to support communities and families where these children live.

With the growth of the Hospital, we are launching new services for select surgical interventions for adult neurological conditions on an affordable for-fee basis. This is founded on our core competence and proven success in an interdisciplinary neurosurgical care, collaboration and holistic approach to healing and outcomes management that have helped ensure our patients grow up to be functional adults.

Through funding from the ASHA program under the US Agency for International Development (USAID), CURE CHU now has a third operating room (theater), as well as a high tech ward fully installed with monitors to the level of an intensive care unit. This ward space will provide services to adult patients who desire privacy, whom also expect the high-quality post-operative care CURE has become known for.

The new OR theater has been designed and equipped to provide select spinal surgeries and an approach to pituitary tumors in the brain without opening the skull. This approach uses an endoscopic technique through the nose, and will be the first of its kind in East Africa. These services, for both adults and children, result in faster recovery times, shorter hospital stays, less risk and fewer problems than traditional approaches. The expansion in services and facilities is timed with an increase in human resources to manage higher patient CURE children's hospital extends services to more Ugandans Story continued from page 18 volumes. CURE CHU is home to Uganda's only two pediatric neurosurgeons. With another two completing their neurosurgery training in 2014 and 2017, the hospital is ready to buttress its reputation as a center of neurosurgery in Uganda.

Most of our patients are from very poor backgrounds. The majority of them are not able to afford the full costs of surgery and treatment. These expanded services and facilities will be a source of additional revenue to enable us to help even more disadvantaged and low-income children. In this challenging global economic environment, Ugandans helping Ugandans, keeping valuable Shillings with the country, is one of the best solutions to improving the healthcare system for Uganda.

Integration of health service delivery during outreaches – An experience from Kabarole district

By Dr. Jairus Mugadu
Clinical Services Officer – UPMB

There is evidence that integrated disease prevention increases coverage, is equitable and efficient in controlling high burden infectious diseases. Acceptability and effectiveness of this approach had never been evaluated in UPMB HIV implementing facilities.
In our bid to achieve the objectives of the HIV project, UPMB participated in the 2013 Rotary family health days, taking advantage of the mobilization that Rotary clubs around the country had done to increase demand for various health services. From 7th – 11th May 2013, a team from UPMB was in Kabarole offering several health services which included Safe Male Circumcision, immunization, family planning, general treatment of common ailments and HIV counseling and testing.

The LC V chairperson Kabarole district with UPMB staff and clients during the RFHD

The aim of the Rotary family health days was to offer services to at least 1,000 people in 6 days, 700 of which were to receive SMC services. Two (2) temporary sites based at schools (Rubona and Kaboyo) in strategically dispersed locations were used and they offered: HIV counseling and testing, male condoms distribution, Family planning, immunization, de-worming, and general outpatient services including screening and treatment for hypertension, diabetes and Malaria among others.

Mobilization was done using multiple methods which included using radio talk shows and announcements, banners and use of community mobilizers.

Results and outputs:

A total of 519 males were circumcised and of these, 420 (80.9%) were between 10 & 19 years; 462 received HCT with only 9 (1.9%) being reactive; 60 clients were screened for Malaria using Rapid diagnostic tests (RDT) and 10 tests were reactive. 45 clients were screened for diabetes and their blood sugar was found to be within normal ranges.

Surgeons during SMC

General outpatient (OPD) services were offered to 205 people including 9 with Malaria, 12 Hypertension, 38 had upper respiratory Infections (UTRI), 6 were diagnosed with Urinary tract infections (UTI) and 125 had other ailments.
A total of 273 children under 5 years were immunized using various vaccines as was appropriate according to their ages, 74 children received Vitamin A and 61 women of reproduction age got Tetanus toxoid (TT) vaccines.

Major challenges:

The major challenges encountered included inadequate time for mobilization and shortage of consumables like SMC kits and drugs.

Lessons learned:
The involvement of local leadership is very important for the success of integrated health interventions. The camp model is the easiest way to achieve SMC numbers at short time but this should be after adequate mobilization using radio, banners and mega loud speakers.

Recommendations:
Implementation of such activities requires community mobilization strategies that are carefully crafted to suit the target population and therefore should start early using a combination of approaches starting with stakeholder meetings and later on using media such as Radio, TV and IEC materials. Additionally, it should not escape the attention of managers or coordinators that proper forecasting of all consumables is necessary.

The African Partnership for Patients Safety Programme [APPS] at Kisiizi Hospital

By Dr. Ian Spillman
Medical Director
Kisiizi Hospital

Kisiizi, as the only hospital in Uganda in the first-wave of the World Health Organization [WHO] African Partnerships for Patient Safety programme [APPS] has conducted a range of activities including reduction of hospital acquired infection, use of the WHO Safe Surgery Checklist, safer prescribing, waste management etc.

Practical initiatives linked to this include the in-house production of alcohol-based hand rub for Staff to utilize at every patient contact. This is effective but takes much less time than washing with soap and water. This year the hospital ran an amplification sessions with a Sensitization Seminar and then a month later two Training Days for all the Health Centre IV's, Hospitals and Health Training Institutes in our neighboring two districts with a 100% uptake of the APPS programme. WHO facilitated a team of four to come from Ndola teaching hospital in Zambia to attend the training and to then go back to roll out the programme in Zambia.

Following excellent evaluation, Kisiizi hospital was asked to take part in a new WHO initiative supported by John Hopkins University in USA, the Surgical Unit-based Safety Programme [SUSP]. Our Consultant Surgeon, Dr. Gabriel Okumu, has just returned from WHO Geneva where he attended the pilot strategic planning session.

Uganda was represented by Mulago and Kisiizi hospitals, in a meeting that attracted participants from Malawi, Kenya and the Consultant Surgeon from Ndola who had attended our training represented Zambia.

Another vital focus of WHO is Universal Health Coverage, the goal of all people having access to good quality health care.

Kisiizi has one of the largest Community Health Insurance Schemes in east Africa with the extraordinary figure of over 35,000 people registered.

These come from 173 local groups up to 60km from Kisiizi in the four districts of Kabale, Rukungiri, Ntungamo and Kanungu. The group leaders are enthusiastic, and we have a vision for developing health promotion through this network and through the church which is also ideally structured to cascade information through to the parishes.

WHO is very interested in the opportunity to link Patient Safety and Universal Health Coverage and so Kisiizi has been selected as one of only five worldwide “learning laboratories” to research what really works on the ground.

We trust that with God’s help we will further expand access to good health care to our very poor community and that the health promotion initiatives will impact the prevalence of common diseases and reduce some of the tragic cases we sometimes see presenting too late. We would value communication from our UPMB colleagues re similar initiatives and practical approaches you have found helpful. May we together bring Life in all its Fullness to our patients and communities.

Bwindi Hospital partners with Star South West on the SMC program

In collaboration with Star SW, BCH is implementing a Safe Male Circumcision (SMC) program geared towards circumcising all males in the Bwindi area.

A queue of individuals waiting to be circumcised.

The program is aimed at reducing HIV prevalence in the area due to the compelling evidence from different studies that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. On average, the hospital circumcises 150 people majority of these being school children. Although Male circumcision provides only partial protection, BCH provides an element of a comprehensive HIV prevention package which includes: the provision of HIV testing and counseling services; treatment for sexually transmitted infections; the promotion of safer sex practices; the provision of condoms and promotion of their correct and consistent use. The hospital is grateful to Elizabeth Glaser Pediatric Aids Foundation (EGPAF) for enabling us render the much needed service in this area.

RWESANDE HC IV ON THE ROAD TO PROGRESS

By Dr. B.K Seth Tibenda
Medical Superintendent
Rwesande HC IV

Management and staff of Rwesande HC IV give thanks to the almighty God for giving good Samaritans to the facility who have added value to our service delivery catalogue. The facility is situated in the Ruwenzori but offering Health Care service to Humanity. Below we give a tour of what has been achieved in the last one and half years

THE MATERNITY HUT:

This building was acquired with support from UPMB under the MNH programme - a programme designed to reduce maternal and neonatal mortality. The hut was constructed to house Expectant Mothers – especially those from distant places and about to deliver so that they come and wait in this building for the onset of labour such that at the beginning of labour, they are transferred to the Maternity ward (picture adjacent to the hut). 118 Mothers have utilized the hut since January 2013.

The Ambulance:

Donated to Kasese district Local Government (KDLG) by SAVE THE CHILDREN UGANDA, the local government decided to give the ambulance to Busongora North HSD whose Headquarters are at Rwesande HC IV. Now expectant mothers and other critically ill patients in the HSD can easily be picked from wherever they are getting challenges in their life to other treatment centers where probably a solution to their life challenge can be coined, thanks to the leadership of Kasese District and Save the Children Uganda.

Rwesande HC IV Main Block gets a face lift

This has been accomplished by STRIDES for Family Health with assistance from the American People through Funding from MSH by USAID. For a person who has never visited Rwesande HCIV, one would think Rwesande is a newly constructed health center – our sincere appreciation to the management of Strides for Family Health and the District leadership who went into agreement to have Rwesande reno-

vated, have a look! This was a dilapidated Building pausing lot of life threats to Patients and staff that were receiving and Offering Health care sere service respectively. A smile has been shed to all groups of people who walk into this building either to offer service or to receive the services, it was furnished with a 240 Watt solar inverter that enables the rural centre to operate a Computer and the electric Microscope, the CD 4 Pima to operate and give a sigh of relief to her beneficiaries. A very big thank you for all players to make Rwesande HCIV a new service delivery point. May God bless you and instill a healing hand upon the service providers at Rwesande.

UPMB builds capacity of member facilities to provide PMTCT Option B+

By Zabia Namulawa
HIV Prevention Officer - UPMB

A facilitator demonstrating in one of the sessions

To contribute to the National strategy of scaling up PMTCT Option B+, a total of 27 Health Services Providers in all the NESH supported sites went through a 6 days training as recommended by MoH. The training was conducted in April 2013 and cadres trained included Midwives, Doctors, and Clinical officers, Nurses, Counselors and Laboratory Technicians.
After the training, re-testing in late pregnancy, PNC and in Maternity has been appreciated and this has increased on the HIV+ women initiated on Option B+.

CARE FOR EXPOSED INFANTS

By Zabia Namulawa
HIV Prevention Officer - UPMB

UPMB, through the NESH implementing sites is contributing to the National scale up of EMTCT through provision of ART to all HIV+ Pregnant and lactating women and ARV prophylaxis (NVP syrup) to all infants born to HIV+ Mothers.
Early initiation of ARVs among HIV+ Pregnant and lactating women, lowers the Viral load thus reducing the likelihood of HIV transmission to unborn or breastfeeding babies respectively.

A midwife initiating a 1 day exposed infant on ARV prophylaxis (NVP syrup) at Azur HC IV

Global fund, through MoH, has ensured availability of ARVs for mothers' re-fill and Nevirapine syrups for exposed infants starting immediately after delivery and continuing up to 6 weeks. At 6 weeks, Nevirapine syrup is stopped, a DBS is taken for PCR testing, cotrimoxazole prophylaxis is initiated and the mother is referred for Family Planning services.
Specialized care such as clinical assessment for opportunistic infections, monitoring development milestones, baby's height, weight, and other services are provided at the EID care point- a place where care givers come for in-

Ruharo Mission hospital scales up provision of SMC, HCT and EMTCT services

By Andrew Senjovu
Monitoring and Evaluation Specialist
Ruharo Mission hospital

Ruharo Mission hospital with support from Uganda Protestant Medical Bureau is implementing the NESH program, a program aimed to strengthening HIV/AIDS and TB services in Uganda. The program supports the provision of comprehensive HIV/AIDS services to people infected and affected by HIV/AIDS. Through the program, the hospital has been able to scale up provision of the following services;

- *Safe Male Circumcision*
- *PMTCT services*
- *OVC services*
- *HIV counselling and testing*
- *AB/ABC services*
- *ART services*
- *TB/HIV services*

Ruharo Mission Hospital SMC services extended to Kakiika prisons

Prisoners at Kakiika being counseled for SMC

Being one of the major strategies to reduce HIV/AIDS infection in various communities, SMC has been extended to various places in and out of Mbarara district. These include village health centers, market places, prisons and general communities. Over 300 prisoners at Kakiika prison tested for HIV/AIDS. So far 94 prisoners have been circumcised and over 200 prisoners still need the service

Scale up of Elimination of Mother to Child Transmission (EMTCT) of HIV/AIDS

Mothers waiting for the services

As part of the child health services, the Hospital continued to PMTCT services under the expanded program on NESH. PMTCT services provided by the hospital are growing at a steady rate. Among the services provided are: Immunization, Family planning, Neonatal and maternal child care, ANC and PNC services. These services are steady improving as a result of the support received from UPMB to support the activities

OURS' Program at Ruharo Mission Hospital

Pictures show a child with club foot before and after surgery

OURS' (Organized Useful Rehabilitation Services) is a community based rehabilitation program aimed at promoting inclusion into society, equal rights and empowerment of CWDs and their families through increased provision of quality, affordable and comprehensive rehabilitation services. 'OURS' offers services to poor children with different types of disabilities up to 18 years who come through parents who have received services from the hospital, referrals, on their own, through radio announcements or identified through Outreach activities. Through our teaching OURS has been able to minimize stigma against disability and promoted equal rights and participation to children with disabilities. OURS offers both centre and community based services to children with different disabilities like clubfoot, spina bifida, cleft lip/palate or deformities, cerebral palsy, limitations in movements after burns, paralysis of the legs after injection.

ACTS 1 : 7-8

ACTS 1 : 7-8

Uganda Protestant Medical Bureau
Plot 877 Balintuma Road, Mengo
P.O Box 4127,
Kampala – Uganda
Tel: (+256) (0) 414271776 | Fax: (+256) (0) 414341413
Website: www.upmb.co.ug

Any information to be shared, send to jmiyonga@upmb.co.ug or miyojonah@gmail.com