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THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

NEWBORN HEALTH Magazine

"Small Actions, BIG IMPACTS: Immediate skin-to-skin care for every baby everywhere."

WORLD PREMATURE DAY Commemoration

Theme: " Small Actions, BIG IMPACT:
Immediate skin-to-Skin Care for Every Baby Everywhere"

Guest of Honour:
Margaret Muhanga, Minister of Primary Health Care

Date:
17th November,
2023

Venue:

Queen Elizabeth Nursing
School Ground, Mulago



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EDITORIAL

Dear Readers,

Welcome to Issue 5 of the Newborn Health Magazine! This edition marks our tribute to World Prematurity Day on November 17th. Every year, 15 million babies are born prematurely – more than one in ten of all babies around the world. In Uganda, almost one third of neonatal deaths are attributed to preterm birth related complications.

This year's theme, "Small Actions, BIG IMPACTS: Immediate Skin-to-Skin Care for Every Baby Everywhere," highlights the transformative power of immediate skin-to-skin contact and Kangaroo Mother Care (KMC) for preterm infants. We extend our gratitude to our partners and authors for contributing to this insightful collection.

As you delve into these stories, join us in raising awareness and advocating for the challenges surrounding preterm births. Thank you for your vital support. Enjoy your reading!

Warm regards,

EDITORIAL TEAM

01 **Richard Businge**
Head of Operations,
NBSC

02 **Waliggo Henry**
Communications Specialist,
NBSC



Cover Image © Uganda/Waliggo Henry



The Chairperson on a Mission, Journeying to Assess Island Health Centers in Mayuge District."

CHAIRPERSON'S UNDERSTANDING OF NEWBORN CARE SERVICE DELIVERY IN UGANDA USING MAYUGE DISTRICT AS A CASE STUDY

The Ministry of Health (MOH) has placed significant emphasis on enhancing service delivery for maternal and newborn care, with the Newborn Steering Committee (NBSC) leading the charge in implementing newborn care services across the country.

Before initiating any training or mentorship programs, the NBSC diligently conducts assessments of health facilities providing maternal and newborn care services. These assessments adhere to the standards and indicators outlined by the World Health Organization (WHO). Each assessment unveils a myriad of insights—some startling, others thought-provoking, and a few that elicit momentary frustration.

However, this frustration is transient because upon deeper analysis, a hopeful realization emerges—the presence of "LIGHT" at the end of the tunnel.

Allow me to recount my recent experience assessing newborn care services in Mayuge district, which comprises three Health Sub-Districts (HSDs): Mayuge HCIV, Kityerera HCIV, and Kigandalo HCIV. In this round of evaluations, we meticulously examined 16 health facilities, encompassing 8 HC IIs, 5 HCIIIs, and 3 HCIVs. I want to shed light on the disparities we uncovered in three critical dimensions: Quality, Equity, and Standards.

● QUALITY

The assessment in Mayuge district starkly revealed the inadequacy and deficiency in the quality of services across various levels of service delivery. The fundamental concept of 5S (Sort, Set in order, Shine, Standardize, Sustain) was noticeably absent in all facilities, including newly constructed ones. Many buildings, particularly on the islands, were in a state of disrepair and unfit for use. Within labor wards, hygiene was compromised, and the presence of outdated beds was pervasive.

A concerning observation was the lack of uniformity among staff, with some not easily distinguishable from patients and others dressed akin to casual laborers. HC IIs, with only three staff members, often found the porter assuming health worker responsibilities due to low delivery rates. Despite the seemingly minimal activity, registers indicated deliveries, hinting at the potential for more if skills and equipment were enhanced.

HC IIIs faced understaffing issues, lacking essential equipment such as oxygen, ventilation bags, masks, and basic suction tools.

Deliveries in these facilities sometimes occurred on ordinary beds or examination coaches, highlighting the precarious conditions under which medical care was administered. Moreover, some units lacked running water, PPEs, and crucial medicines for newborn care. The island's ambulance system, often relying on boats, posed significant risks due to inadequate equipment, absence of health worker escorts, and a two-hour ride to the farthest island.

To address these challenges, a flexible system must be implemented, ensuring that health workers with diverse specializations are stationed on the islands to enhance both quality and accessibility of care. HC IVs, designated as referral centers, fell short of the required standards, with Kigandalo HC IV exemplifying deficiencies, sharing a faulty neonatal ventilation set among multiple units.

In summary, Mayuge district is considerably distant from delivering quality care services for mothers and infants. A comprehensive improvement strategy is imperative to bridge the existing gaps and establish a healthcare system that prioritizes the well-being of its beneficiaries.



EQUITY

The concept of equity, often sung about by the WHO, took on a sobering reality in Mayuge district. Contrary to expectations, services at the same level of care exhibited significant disparities. Infrastructure, equipment, and staffing levels, which one might assume to be uniform, varied widely. This disconcerting observation prompts consideration of whether this is a localized issue or a broader concern across all districts in Uganda.

Facilities at the same level showcased a stark contrast, with some boasting new equipment while others had none.

The extensive distances between facilities exacerbated the challenges of referrals, especially for lower-tier facilities struggling to access the two newborn care units in Mayuge district HCIVs (Mayuge HCIV and Kigandalo HCIV). Kigandalo HCIV, in particular, appeared under-utilized, leading to a noticeable imbalance in the distribution of services. The third Health Sub-District (HSD) lacked a newborn care unit at Kityerera facility.

Despite the addition of new facilities, only a handful can provide Kangaroo Mother Care (KMC) services. Even among those with the necessary infrastructure, the shortage of human resources hampers the comprehensive coverage of Maternal, Neonatal, and Child Health (MNCH) components.

Based on my experiences and interactions, it becomes apparent that addressing the critical issue of human resource inadequacy is paramount. Without a substantial increase in the numbers of healthcare professionals, particularly in the context of maternal and neonatal care, it is improbable to make significant strides in reducing mortality rates. Consequently, any salary increments for healthcare workers should be coupled with a strategic focus on augmenting the workforce, establishing it as a top priority for the government.



Enroute to Remote Health Facilities on a Boda Boda, Ensuring No Area is Left Unassessed for Improved Healthcare in Mayuge District."

STANDARD

The absence of a standardized framework for service delivery is a prevailing issue not unique to Mayuge but reflective of broader challenges in the country. Compounding this, various implementing partners in Mayuge operate with distinct standards, each employing its own Health Management Information System (HMIS) forms, clinical protocols, and training approaches. Notably, not all partners align with the World Health Organization's (WHO) training courses for Helping Mothers Survive (HMS) and Helping Babies Survive (HBS), leading to confusion and inconsistency in the quality of training.

The lack of oversight on trainers/mentors adds another layer of uncertainty regarding their capabilities to deliver prescribed training packages. As the chairperson of the Newborn Steering Committee, the initial frustration is palpable. Yet, upon deeper reflection, it is clear that beneath the challenges lie opportunities for improvement.

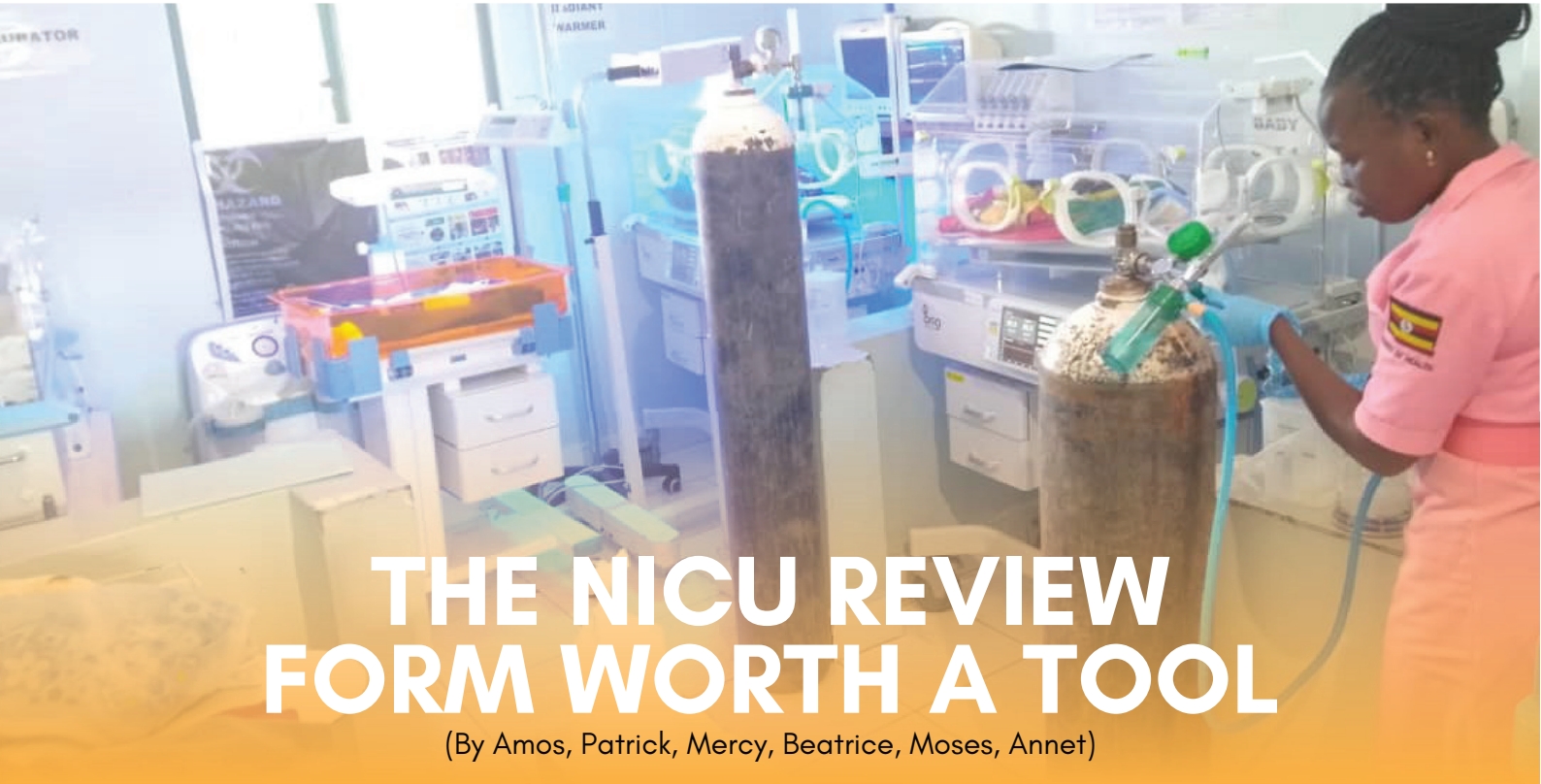
In contemplating this complex landscape, I draw inspiration from a profound offer: "Come to me, all you who are weary and heavy-burdened, and I will give you rest," as articulated by Jesus. The aspiration is for health facilities to become places where mothers and their babies find solace and relief. While the road ahead may seem daunting, a positive outlook reveals more opportunities than challenges.

“

Addressing this scenario requires meticulous planning and strategic programming. The key lies in mobilizing additional resources and directing them purposefully towards the right causes. By doing so, there is a strong belief that positive transformations can be achieved, creating an environment where health facilities truly embody the promise of rest for those they serve.

For God and my Country





THE NICU REVIEW FORM WORTH A TOOL

(By Amos, Patrick, Mercy, Beatrice, Moses, Annet)

Follow up of patients is a very important approach in determining the progress of patient care after discharge.

In Koboko Hospital NICU following discharge, preterm babies are always scheduled for review every Wednesdays after every 7days, 14days and 28days depending on individual baby's assessment outcome.

In Koboko NICU where majority of the staff are mentored at site, there has been a challenge in reviewing the babies as key parameters could be missed out time-to-time.

In a bid to promote staff competence and uniformity of care, we decided to design and adopt a user friendly review form particularly for the preterm babies to track their progress which translates the level of care while at home and guide us in making case-specific timely interventions.

In the FY 2022/23, all the 140 preterm babies were each discharged with this form, to be carried along during every review visit.

We noted a reduction in lost-to-follow-up rate (First Visit FY 21/22 40% ie 52/130 discharges FY 22/23 15.7% ie 22/140/ discharges not reviewed).

KOBOKO HOSPITAL NICU - REVIEW FORM												
Name..... Sex.....D.O.B..... Birth Wt (g).....												
Address..... IP No.....												
Date	Age(days)	Bwt (g)	Wt gain (g/kg/day)	Temp (0C)	HR (b/m)	RR (b/m)	SPO 2 (%)	HC (cm)	Present Complaints	Recommendation/intervention	Return Date	H/W Name

The NICU Review Form worth a tool

Staff experienced the following benefits from adopting this tool;



- 1 Uniform step-by-step assessment of babies by all staff promotes client satisfaction and compliance to follow-up schedules.
- 2 Promotes staff competence in assessment due to consistency in follow up and saves time.
- 3 Easy to track progress of the babies hence appropriate interventions (like relevant health education, re-admission, complications, refer patient, discharge from follow up among others).
- 4 Makes it simple to interpret findings to mothers which motivates them to concentrate on agreed recommendations.
- 5 Guides health workers from referring facilities where they can review the babies conveniently without necessarily traveling long distances to the NICU.

With all its benefits experienced, we have highly embrace and adopted this form as guiding tool in the routine care of preterm babies after discharge.



● Nurse Patrick taking Head circumference during review



● Nurse Patrick recording in the review form

Mental health challenges of parents caring for preterm babies in the Neonatal Intensive Care Unit

(By Ann Jacquelline Nakitende, Dr. Jesca Nakibuka, Dr. Jolly Nankunda, Dr. Evelyn Nabunya)

Affiliation: Mulago Specialized Women and Neonatal Hospital, Kampala Uganda

Mental health remains a major public health concern that deserves maximum attention as it cuts across all disciplines of wholistic wellbeing.

Pregnancy is a joyous milestone in every parent's and/ or family's life. It manifests with physiological and psychological changes. Notably however, the birth of a preterm baby leads to excesses of emotional and psychological distress to the parents/families.

Parents and families with a preterm baby express mental health challenges depending on the gestational age at admission and the duration for which a preterm baby is admitted in the Neonatal Intensive Care Unit (NICU). Parents express anxiety and depressive symptoms which are exacerbated by the intensity of the NICU environment. Parents see lots of tubes and wires going into their babies and this is upsetting. Various thought processes that include comprehending the medical information pertaining to the care of the preterm, guilty feelings around the cause for the preterm delivery including a sense of helplessness and failure as a woman for not having been able to carry the pregnancy to term, self-blame and blame from relatives for having been the cause of the preterm birth and question the mother's adequate attendance of antenatal visits manifest. Some express self-stigma and enacted stigma from other people for having a preterm baby.

“

Mental health remains a major public health concern that deserves maximum attention as it cuts across all disciplines of wholistic wellbeing.

Parents and family members that stay for long nursing their preterm baby express anxiety and depressive symptoms that are triggered by financial constraints, evolving health condition of the preterm baby, abandonment by significant others in the care and emotional support of the mother and uncertainty of the developmental outcomes of the preterm baby. The social dynamics of the individual mother of a preterm and the family are disrupted sometimes to extremes of family discord.

Therefore, there is great need to have psychological interventions for parents and families with preterm babies. These psychological interventions will help parents and families to address anxiety, depressive symptoms, traumatic feelings, rejection, deal with stigma, self-esteem, self-acceptance, self-blame, promote self-compassion. All these help the parents and family to cope positively and heal faster and this translates into good outcomes for the preterm baby.

PRETERM CARE THE COMMUNITY ASPECT.

What next after discharge of a premature?

“Born too soon” is challenge enough to mother and baby, care in the facility comes with a lot of constrain too but going home with a preterm baby is another ocean to cross.

At the hospital, when the warmth has been provided, the medication given, the careful feeding options observed, the infection prevention practices , parent counselling coupled with the averagely longer duration of stay compared to their term baby counterparts, premature babies still have lots of challenges awaiting them at the community after discharge.

“

“Born too soon” is challenge enough to mother and baby, care in the facility comes with a lot of constrain too but going home with a preterm baby is another ocean to cross.

A portion of the discharged well either die or return to hospital within a short time interval with their babies being unwell. Below, are some of the highlighted challenges at the community level.

- 1 Community interaction of a premature baby with siblings and other family members especially school going siblings who predispose these premature babies to recurrent illnesses like pneumonia and eventually increasing their risk to dying. This is partly contributed to by the poor housing infrastructure that doesn't allow for isolation of the premature baby from other family members.
- 2 Lack of partner support: most of these mothers are not embracing Kangaroo Mother Care(KMC) effectively due to divided responsibilities in a home as some partners are not willing to help out in executing both the KMC therapy and running the daily routine roles in a home.
- 3 Short work leave : Some employed/cooperate mothers have limited time to effectively care for their babies with some employers insisting on either leaving baby home or carrying baby to workplaces which often don't have premature friendly atmosphere and thus predisposing to illnesses and eventually readmissions.
- 4 Lack of knowledge and skill for some of the lower health facilities health workers in care and follow up of these premature babies for example babies that need nasal gastric tube(NGT) replacement often times return to the national referrals for replacement, something that could be done at the health centre level.
- 5 Wrong myths and speculation from caregivers, relatives and some media personnel on care of these premature babies for example the need to bathe a baby before they make 2.5kg which may in turn predispose to hypothermia and eventual mortality.

Therefore: below are some of the recommendations to the challenges highlighted above.

- Involve the CHEWs, formerly VHTs by training them on basic care for premature babies like KMC, encourage mothers to attend follow up clinics and act as a link to the facility level care as it has been done in community care of HIV patients. This will improve community care aspect of the vulnerable neonate.
- Empower and support the national referrals as well as some premature parent associations in educating family members, identifying vulnerable parents and promoting occasional home visits to some of the vulnerable communities.
- Continued training and skilling of all health care providers in basic care of a preterm baby at all levels of health structure.
- Policy review and amendments of maternal leave duration /employer flexibility on maternal leave and work station friendly infrastructure for parents having preterm babies especially those babies born with gestation age of less than 32 weeks.

In conclusion, with the increasingly high trends of preterm births in Uganda, the need to reduce the morbidity and neonatal mortality contributed to by being 'born too soon 'should not only focus at the excellent facility care but importantly encompass community care in our health care package.

Dr. Geraldine Basanyukira
Paediatrician
Kawempe National Referral Hospital.

The Fruits of Regional referral led integrated Clinical mentorships and support supervision program.

A Case of Yumbe Regional Referral Hospital

(By Mubarak Nasur, Semanda Innocent, Musis Buga Magidu Salama Asibazuyo, Adong Judith, Anena Mastura, Asina Hawa, Otua Zaina, Shamira S.)

Background:

Neonatal mortality remains the high in low-income countries and a significant number of these deaths is attributed to death from severe asphyxia, prematurity complications and sepsis (Workineh et al., 2017).

Reviewed records from new born unit in Yumbe RRH indicated significant referrals from the lower level facilities particularly HCIVs and General Hospitals and death mainly from hypothermia, prematurity complications among the newborns referred resulting into mortality rate of about 14%-15% cases in Q1 and Q2 respectively. Further analysis of the issues revealed a number of challenges ranging from limited knowledge and skills for managing small and sick newborns hence frequent referrals, irregular power supply, None functional MPDSR committees, irregular clinical Mentorships and support supervision in New born care and inadequate HRs.

The referral hospital with support from MCH partners like Enabel carried out an assessment which resulted into supporting HC IVs with equipment, Solar power and regional referral with funds to functionalize and conduct regular clinical mentorships to these facilities.

QUARTERS	INDICATORS	HOSPITAL & RR			
		MOYO GH	YUMBE RRH	KOBOKO GH	TOTAL
Q1	TOTAL ADMISSION	182	136	166	484
	TOTAL DEATH	9	19	14	42
	MORTALITY RATE	5%	14%	8%	8%
Q2	TOTAL ADMISSION	159	143	160	462
	TOTAL DEATH	12	21	20	53
	MORTALITY RATE	7%	15%	12%	11%
Q3	TOTAL ADMISSION	149	172	192	513
	TOTAL DEATH	9	5	9	23
	MORTALITY RATE	3%	9%	5%	10%
Q4	TOTAL ADMISSION	185	234	201	620
	TOTAL DEATH	9	18	16	43
	MORTALITY RATE	4%	8%	8%	7%
FY 2022/23	MORTALITY RATE	6%	9%	8%	8%

Newborn Death dropped from 14-15% to 8% by fourth quarter of 2022/23

The best practices that reduced the newborn death rates from 15% to 8% in 6 months only were:

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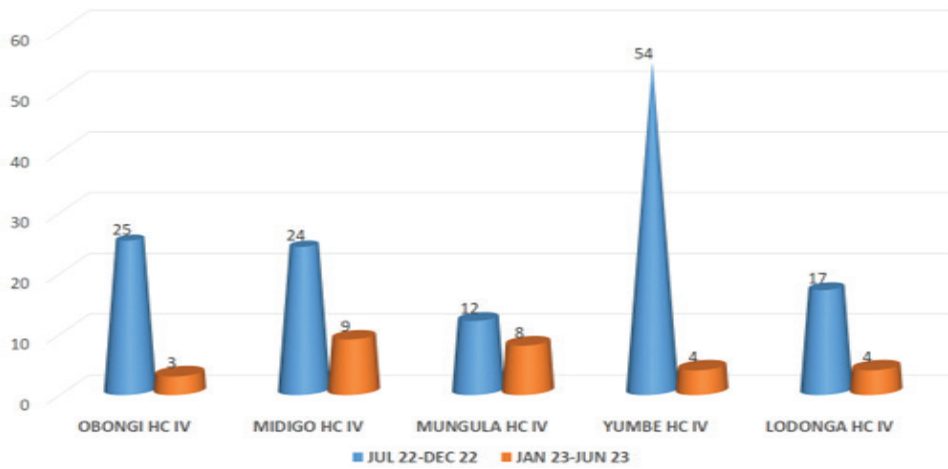
Regular clinical mentorships and technical support supervisions led by the referral hospital team in all the GH and HCIVs.

One month attachment of health workers from high volume HCIIIs and HC IVs to the referral Hospital NICU.

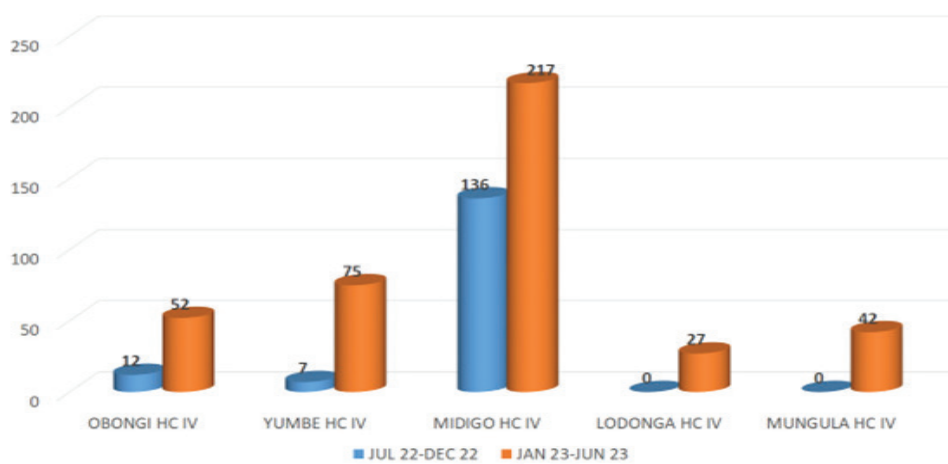
Integration of Local maternity neonatal systems mechanisms into primary health care package led by the RRH.

Promotion of skin to skin KMC during referrals. Lobbying Partners to support to install and functionalize NCUs in all HCIVs plus equipping with solar panels and standby generators with fuel budget lines.

TREND OF REFERRAL OUT IN HC IVs FOR FY22/23



A BAR GRAPH SHOWING TREND OF ADMISSION IN HC IVs



The functionalization and regular clinical mentorships in the HC IV NCUs and resulted into increases admissions and hence reduced referral.



Clinical Mentorship by the regional referral team in Obongi HCIV.



PROGRAM OVERVIEW

MARCH, 2023



Uganda Newborn Programme

BACKGROUND

ELMA philanthropies has initiated “the Uganda Newborn Programme (UNP), an investment involving a consortium of five partners together with Ministry of Health to consolidate and replicate the most effective newborn interventions in 20 districts in three regions of Uganda (Western, Kampala and North-Central). The partners will utilize their technical strength, attributes and complement each other to coordinate and expand the implementation of an intervention newborn care package and build data-driven evidence on service delivery

improvements at each implementation site. Implementing partners will leverage their existing district-wide health systems strengthening platforms for maternal newborn health and PMTCT to drive evidence-based quality improvement efforts at high volume hospitals and health center IV facilities. Partners include Makerere University School of Public Health, Baylor Uganda, Adara Uganda and Nsambya hospital.



AIM

To improve the care for 120,000 small and sick newborns over three years and reduce newborn death by 40% at target hospitals.

OBJECTIVE

To expand and institutionalize evidence-based newborn care services to reach 120,000 small and sick newborns through strengthening clinical competencies of health workers in advanced care for small and sick newborns; improving infection control and strengthening clinical practices by institutionalizing quality Improvement processes

TARGET SIZE

120,000
Small and sick newborns

20
high-burden districts

3
regions of Uganda

1.5M
Serving 1.5 million births annually

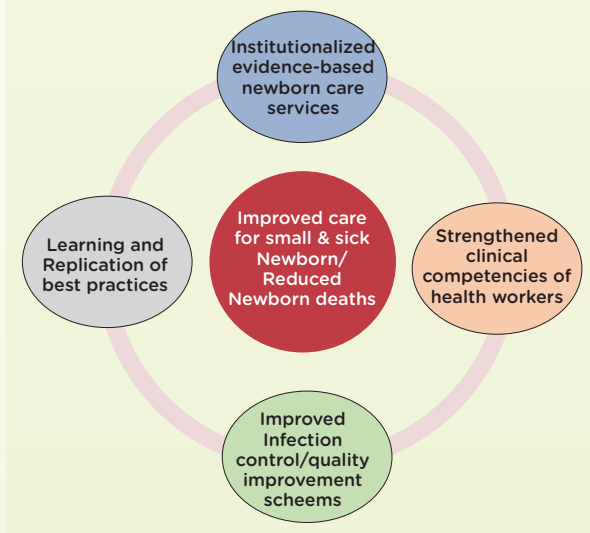
INTERVENTION

The program consolidates and replicates most effective newborn interventions in 20 districts in three regions including;

- Refurbish, and equip 30 specialized care units for small and sick newborns in line with the NEST Newborn Implementation Toolkit
- Strengthen clinical skills of 2,000 health workers in neonatal resuscitation, Kangaroo mother care, CPAP, and infection control to appropriately manage neonates
- Improve infection control using quality improvement measures and documenting the burden of sepsis and antimicrobial resistance among newborns at Regional Referral Hospitals
- Post-natal follow up of newborns discharged from neonatal units

- Implement national guidelines and treatment protocols for the care of small and sick newborns. Improve partner coordination by augmenting the National and Regional Newborn Steering Committees.

Theory of change: Improved care for small and sick newborns and reduced deaths of newborn



PROGRAMME ACTIVITIES

Expand and institutionalize evidence-based newborn care services to reach 120,000 small and sick newborns

- Conduct a newborn situation analysis to identify gaps in capacity and quality of service, refine three-year targets and support MOH to develop national targets for small and sick newborns based on evidence generated by partners, NEST, and WHO
- Establish and equip neonatal units at 30 district hospitals and

Funding: This work is supported by the ELMA Philanthropies.

- other high-volume facilities
- Develop and implement standardized guidelines and protocols for small and sick newborns for all point of care levels
- Facilitate MOH to lead newborn stakeholder coordination and strengthen the National Newborn Steering Committee
- Conduct monthly perinatal death audits, support data quality review, and provide technical assistance to district health teams to utilize data for decision making
- Strengthen the referral system and conduct monthly integrated MNH outreaches to lower-level facilities and distant communities
- Train and equip VHTs to mobilize communities and conduct postnatal care home visits within three days post discharge of the newborn.

Strengthen clinical competencies of health workers in advanced newborn resuscitation

- Provide in-service skills-based training and mentorship for six-member dedicated health worker teams at each facility in caring for small and sick newborns (resuscitation, warm transportation, infection control, and Kangaroo Mother Care)
- Procure from Hatch and supply the essential equipment recommended in the NEST bundle (CPAP, phototherapy, Pulse Oximeters, resuscitation bag and masks, etc.) in line with the Target Product Profiles for low—resource settings.
- Conduct quarterly quality improvement driven onsite staff mentorship and technical support supervision for improved clinical case management through data review
- Distribute and train health workers on MOH newborn care

- guidelines and case management protocols
- Convene bi-annual district-based newborn health quality improvement learning sessions in the 20 districts
- Conduct quarterly mortality audit reviews and analysis to inform health worker training and service delivery improvements

Improve infection control and strengthen clinical practices by institutionalizing quality Improvement processes

- Train 720 facility-based health workers in infection control at target hospitals and health facilities
- Implement targeted quality improvement projects focused on managing and controlling infections among newborns
- Establish and support peer to peer support groups within facilities to ensure adherence to infection control protocols
- Provide mentorship and conduct quarterly support supervision for health teams on infection control
- Conduct a sepsis study in three regional referral hospitals to establish the sepsis burden and antimicrobial resistance among admitted newborns and share results with MOH.

Learning and replication of best practices

- Document and disseminate best practices
- Conduct rapid operational research to identify effective quality improvement and community care models
- Provide data driven evidence to promote and support scale up of newborn care models that work

IMPLEMENTING PARTNERS



MAKERERE UNIVERSITY

MAKERERE UNIVERSITY SCHOOL OF PUBLIC HEALTH (MaKSPH)

Coordinates consortium partners, engage with MoH and professional bodies (Uganda Pediatric Association, National Newborn Steering Committee) to provide data-driven evidence of approaches and models that work, distill critical insights and lessons that can be replicated, support development of national guidelines and protocols for the care of small and sick newborns through the Makerere University Centre of Excellence for Maternal Newborn & Child Health (MNCH)



BAYLOR UGANDA

Supports eight district hospitals, 16 health center IVs, and 34 health center III targeting 25,000 newborns in the Rwenzori and Bunyoro sub-regions of Western Uganda. Baylor is training and mentoring health workers, leading refurbishment of NICUs with equipment and strengthening district capacity to plan and deliver quality improvement projects while improving collection and use data for decision making.

FUNDED BY:



NSAMBYA HOSPITAL

Supports expansion of newborn package of interventions to five high volume private-not-for-profit (PNFP) referral hospitals in central region estimated to reach 25,000 newborns. Collaborates and supports Kampala City Authority to strengthen and coordinate the newborn focused referral network across supported private and public hospitals.



ADARA UGANDA

Implements the newborn package of interventions in eight facilities (two hospitals and six health center IVs) across three districts in mid-central region targeting 15,000 newborns

PROJECT TIMELINE

JULY 2022 - JULY 2025

MEASURES OF SUCCESS

- ↓ **40%** reduction in newborn mortality rate (NMR)
 ▶
of newborn lives saved in target hospitals over grant period
- ↓ **30%** Reduction in birth asphyxia case fatality among newborns.
 ▶
↓ **50%** Reduction in small and sick babies admitted to the neonatal unit with hypothermia
- 80% of target Health Center IV facilities supported to deliver the full newborn intervention package.
 ▶
95% cesarean deliveries attended by trained and equipped newborn resuscitation teams.
- # of target facilities with appropriate and functional equipment as defined in the NEST Implementation Toolkit (CPAP, Phototherapy, Radiant Warmer, Pulse Oximeter, etc.)
 ▶
90% adherence to infection control standards across target hospitals
- Improved identification of prevalence and magnitude of sepsis in neonatal units in hospitals with lab facilities
 ▶
<5% babies in neonatal ward with late onset of sepsis (>72 hours post-delivery) at all target hospitals
 ▶
% of newborns with suspected sepsis, who are screened, and lab results received
 ▶
90% of newborns with susceptible infections are given appropriate treatment
- ▶ Small and sick newborn care guidelines and protocols standardized and adopted nationally



MONITORING AND MANAGEMENT

The Project Management Committee at MakSPH brings together implementing partners on a quarterly basis to monitor performance against work plans, share success, and determine course correction strategies. A Steering Committee will meet biannually and will bring together relevant government representatives and leadership of the implementing partners to ensure programming is harmonized with government priorities.



SUSTAINABILITY

The project is implemented through existing MOH structures and health staff supported by consortium partners to promote efficiency and performance. Activities are informed by the HMIS data and are designed with MOH direction and support. The built skills among staff will lead to new clinical case management protocols, and acquire new competences to sustain new processes and practices, partners will engage district leadership to promote program ownership through harmonized planning, partner coordination, joint monitoring, and data utilization to enhance quality service provision

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Adaranewborn: Scaling Newborn Care Through A Regional Model

NOVEMBER 2023

By Adara Development

UGANDA WORLD PREMATURITY DAY

Despite making significant gains in reducing newborn deaths, data shows that Uganda is not on track to reach the Sustainable Development Goal (SDG) for maternal and newborn mortality.

With 25 years' experience working in partnership with Kiwoko Hospital to develop a Centre of Excellence, Adara has developed the AdaraNewborn model. AdaraNewborn is an evidence-based, high-impact model with the power to halve newborn deaths and stillbirths. Adara has plans to implement this model across 10 health facilities in Uganda over the next decade.

AdaraNewborn spans the continuum of care, improving outcomes across five arms: antenatal care, intrapartum care, inpatient care for small and sick newborns, postnatal care for mother and baby, and follow-up and early intervention. It also utilises a regional 'hub and spoke' model that can be replicated nationally and internationally, leveraging recent successes with this approach in Uganda.

What is the AdaraNewborn regional model?

Together with the Uganda Ministry of Health and other implementation partners, Adara will work to establish two hub and spoke networks of maternal and newborn care. A regional referral hospital will serve as the Centre of Excellence at the heart of each hub. Surrounding health facilities will also be strengthened.

Adara's first hub aims to improve the quality of care across Luwero, Nakaseke and Nakasongola districts in Central Uganda. These districts have a combined population of more than one million people. Kiwoko Hospital is in the middle of this hub, acting as a Centre of Excellence and referral facility that can provide higher levels of care. The second regional hub - comprising five facilities in a separate geographic area - will be selected after close consultation with the Ministry of Health and analysis of national and regional data. Adara plans to work in facilities for up to seven years, scaling down their involvement over time as systems change is embedded in each facility.

"AdaraNewborn facilities are selected based on high mortality and referral rates into existing sites," says Daniel Kabugo, Adara's Uganda Country Director. "We can see where the highest risk babies are being referred from and where there is the greatest need."

We will also include lower level health facilities in training and skill-building activities to improve survival before and after referral.

How will this model save newborn lives?

AdaraNewborn will improve referral pathways, build collaboration among local facilities and advance local leadership. This will strengthen the health system, leading to better outcomes for mothers and babies. The model focuses on four key activities:

Leadership and governance: Each AdaraNewborn facility will receive a leadership and governance training programme, as well as ongoing support to drive systems-level transformation, to help strengthen leadership and create sustainable change. Local champions will help to drive this change.

Clinical training and mentorship: A team of expert clinicians deliver training and mentorship, starting with mastery of the fundamental concepts and building to more advanced concepts over time.

The tools to succeed: Adara will help facilities identify the tools and staff they need to succeed and help establish systems to advocate for those resources. When possible, Adara will help provide some basic equipment. Adara will also help strengthen biomedical capabilities in each AdaraNewborn facility by training hospital electricians or engineers to maintain and repair equipment.

Quality improvement systems: Adara will support the facility to implement quality improvement processes to enhance quality of care, such as Maternal and Perinatal Death Surveillance and Response (MPDSR). MPDSR has the ability to create a supportive environment to develop processes to improve care. Adara will also work to ensure there is a sustainable system in place to train new staff.

The model in action

Following a successful year implementing AdaraNewborn at two current sites – Kiwoko and Nakaseke hospitals – Adara has begun work with a third site, Luwero Hospital. This is a public facility that registers more than 3,500 births each year and needs to refer many of these babies to other health facilities – including Kiwoko – to receive more specialised care.

“As we do this work with Luwero, we will monitor where we see large numbers of referrals coming from,” says Daniel Kabugo, Adara’s Uganda Country Director. “We will also be able to see how improved maternal and newborn care at Luwero is affecting referrals into Kiwoko Hospital. The benefit of this model is that we can really see progress on a wider scale – it is embedded in the health system. This will ensure change is sustained long after Adara has exited the facility.”

Over the next decade, Adara plans to reach half a million women and children and prevent over 7,000 deaths. They will impact many more communities by sharing knowledge and resources with health facilities and professionals locally and globally. Adara will continue to work with the Ugandan Ministry of Health to strengthen sustainable systems change. This will save lives now and help reduce maternal and newborn deaths and morbidity into the future.

For more information, please visit Adara’s website – <https://www.adaragroup.org/development/maternal-newborn-child-health/adaranewborn/>



Photo description – The five arms of AdaraNewborn

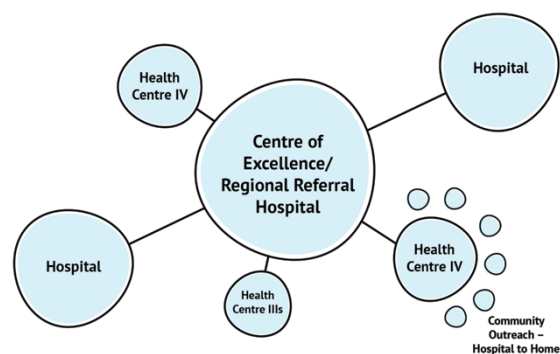


Photo description – Adara’s hub and spoke model



Photo description - A newborn at AdaraNewborn site, Kiwoko Hospital



Photo description - Luwero Hospital's Pediatrician providing support to mother and her newborn



A Glimmer of Hope: Empowering Preterm Parents in challenging circumstances

(By Isabelle K. Furoha Muhindi (Mama Tulia))



global alliance
for newborn care

Life often unfolds in unpredictable ways, and for parents of premature babies, this unpredictability takes on a whole new meaning. The journey of preterm parenthood is fraught with a unique set of challenges, and for those hailing from low-income households and residing in slum communities, these challenges can often appear insurmountable. In our work at Mama Tulia, as we strive to support preterm babies and their parents who give birth prematurely, we have witnessed firsthand the difficulties faced by the economically disadvantaged.

Today, we delve into the stark realities that preterm parents from disadvantaged backgrounds face after hospital discharge.

In this heartfelt moment, Mama Tulia visits a resilient mother who experienced a preterm birth. Together, they embrace the journey of hope, offering support and encouragement to navigate the challenges of early parenthood.



Navigating the Rocky Road:

Challenges Faced by Preterm Parents from Low-Income Households:

Ignorance about Preterm Care: One of the most pressing issues preterm parents from low-income backgrounds face is a lack of knowledge. For many, the day they have a preterm baby is the day they learn about the condition, and in some cases, these are first-time parents. Along with learning about parenthood, they must quickly learn to care for their very fragile preterm infant. The specific care and support needed for their premature babies are received with utter shock. Many are unaware of the intricacies of preterm care, leading to suboptimal post-hospital care for their fragile newborns.

Nutritional Challenges: Ensuring a balanced diet for preterm babies is essential for their growth and development. Low-income families often struggle to provide proper nutrition, even during pregnancy.

When they have a preterm baby, the need for better maternal nutrition becomes ever more pressing, but the lack of means increases concerns about their child's well-being. Access to clean water, a basic necessity, is also often compromised in slum areas.

Inadequate Housing Conditions: Inadequate housing conditions in slum communities can further exacerbate the challenges faced by preterm parents. Crowded and unhygienic living spaces can increase the risk of infections and hinder the baby's recovery, as preterm babies are more susceptible to infections due to their underdeveloped immune systems. Poor living conditions in slum areas and lack of access to healthcare make these infants particularly vulnerable.

Family Tensions and Domestic Violence: The stress and emotional toll of having a preterm baby, coupled with the financial strain of low-income households, can lead to increased tensions within families, resulting in domestic violence. Myths, false beliefs, and societal pressures often point an accusing finger at the mother as the cause of the preterm birth, making her a target for verbal, physical, and emotional abuse.

Financial Strain: The lack of job opportunities and stable employment in slum communities can further add to the financial burden, making it difficult for parents to provide for their preterm infants. The condition requires a significant financial investment, including numerous hospital visits post-discharge, medications, and potential high-cost care for complications.

The Beacon of Hope:

In the midst of these challenging circumstances, Mama Tulia, a dedicated organization, shines as a beacon of hope and support. Through various initiatives, they actively counter these issues and make a positive impact on the lives of preterm parents in low-income households.

Educational Outreach: Mama Tulia conducts educational outreaches, especially in low-income neighborhoods like slums. These programs aim to raise awareness about preterm care, infant nutrition, and hygiene, ensuring that parents are equipped with the knowledge they need to care for their preterm babies effectively

Economic Empowerment: Economic empowerment is crucial for parents who have preterm babies. Mama Tulia offers entrepreneurship training programs, providing parents with the skills and knowledge needed to generate income and secure their family's future.

Financial Assistance: For emergency cases that cannot await the completion of empowerment programs, Mama Tulia provides financial assistance for hospital fees, ensuring that preterm babies receive the care they need without placing an unbearable burden on their parents.

Nutritional Support: Mama Tulia provides food donations to the most vulnerable families, ensuring that both parents and preterm babies have access to the nutritious diet required for their well-being.



Empowering Futures: Mama Tulia shares valuable insights with mothers on building sustainable livelihoods, paving the way for a brighter tomorrow.



Mama Tulia's love knows no bounds as she shares hope and sustenance with mothers who've embarked on the delicate journey of caring for their preterm miracles.

What Mama Tulia does is a testament to what we can achieve as a community in improving the lives of preterm parents in low-income households, particularly those living in slum areas. While the work we do is invaluable, the journey is far from over. The challenges these families face are immense, and they need your support.



Compassionate Care: Nurse Agnes provides crucial preterm information and support to a new mother, helping her navigate the journey with confidence.

We call upon individuals, organizations, and communities to rally behind the cause of preterm babies. Let us join hands in supporting preterm parents from low-income backgrounds and provide them with the hope, resources, and opportunities they need to nurture their preterm babies and give them a fighting chance at a brighter future. In line with this mission, Mama Tulia has recently joined the network of EFCNI and Glance. Your support to any organization, hospital, research, or university focused on preterm babies can make a world of difference, turning the pessimism of challenges into the optimism of possibilities. Together, we can make a lasting impact on these families' lives and empower them to overcome the odds.

HOSPITAL TO HOME: FAMILY CENTRED CARE AND PARENT EDUCATION TO HELP NEWBORNS THRIVE

NOVEMBER 2023

By Adara Development

UGANDA WORLD PREMATURETY DAY

To address an identified gap in newborn care, Adara Development launched Hospital to Home (H2H). H2H is Adara's flagship newborn follow-up programme supporting high-risk infants in the hospital and when they return home. It strengthens care for infants in a neonatal unit through comprehensive parent education programmes and promotion of care that encourages healthy brain development. It also provides regular at-home follow-up support to these vulnerable infants for up to one year after discharge through a network of community health workers (CHWs).

The programme focuses on family engagement and education, involving them in conversations regarding their baby. As part of H2H, Adara takes a family centred approach to discharge planning that includes a comprehensive education programme that prepares the family to care for their infant at home. It includes topics such as breastfeeding, kangaroo mother care (KMC), bathing and skin care, immunisation, danger signs, infection prevention and newborn development.

KMC is especially important for small and sick newborns, who are at higher risk of hypothermia and other adverse health outcomes such as neurological disabilities. As part of the programme, KMC is encouraged immediately after birth and throughout the hospital stay. KMC helps babies regulate their body temperature, bond with parents and improves rates of exclusive breastfeeding. Studies have shown small and sick newborns especially benefit from daily KMC as it leads to increased weight gain, regulation of heart rates and improving oxygen saturations.

The H2H programme creates transformative change in the relationship between an infant's caregivers and newborn unit staff. H2H encourages staff to spend more time connecting with each caregiver and learning about their home environment. This, combined with group education classes and one to one teaching sessions, increase the level of engagement from families.

A clinician from a H2H implementing partner, Kiwoko Hospital, reported that "after H2H things have improved and mothers go home when they are confident and have all the information that they need for their babies." Another clinician agreed adding, "Mothers are confident with what they do because of the classes they attend."

Adara's Hospital to Home (H2H) programme utilises community health workers (CHWs) who have received specialised training in newborn care. These CHWs follow-up babies after discharge from the newborn unit, providing ongoing health education and support. Families are counselled to continue practicing KMC at home and are reminded of its benefits for improved infant growth and survival.

CHWs play an integral role as these visits are not only to assess the infant but also to observe interactions between the mother and baby and help reduce parental anxiety. This gives caregivers reassurance and an opportunity to ask questions.

"Whenever the community health worker could come, he used to encourage me," said one mother in the programme. "I was always eager for his coming; he was updating me about the current state of my babies, and he was also giving me the next step I should take."

Hospital to Home: Family Centered Care & Parent Education

KMC saves lives and improves outcomes for small and sick babies, in the facility and beyond. It is imperative that small and sick babies receive continued quality of care throughout their hospitalisation and after being discharged home, and that parents are involved in the delivery of care. H2H offers comprehensive education and wrap around support for parents to ensure they are confident and have the skills to look after their newborn. CHWs also help identify danger signs and refer those babies for additional care.

Adara has developed a package on their Hospital to Home programme targeted at health professionals and leaders working in hospitals in low-resource settings who want to decrease the risk of preventable newborn deaths. The package includes all the materials and instructions necessary for other facilities to implement their own H2H programme.

To access this package, please visit: <https://knowledgecentre.adaragroup.org>



Photo description - A mother practices kangaroo mother care in the newborn unit

Photo description - H2H Community Health Workers assist a mother with breastfeeding during a home visit.





HARROWING EXPERIENCE OF MIRACLE'S BIRTH

(By: N.Pauline and Joseph Bisaso)

In the quiet village of Tapenensi, where the rhythm of life followed the gentle cadence of nature, an unexpected evening unfolded, shattering the tranquility that had embraced the community for generations.

It all began with a sudden surge of abdominal pain that gripped Tapenensi, a blossoming mother-to-be. In a slow, determined pace, she made her way to the Traditional Birth Attendant (TBA), a revered figure in the village, known for tending to the needs of pregnant women and overseeing deliveries. Like many others before her, Tapenensi had booked an appointment with the TBA, securing her guide through the intricate journey of childbirth.

However, fate took a cruel turn that evening. The TBA, despite her years of experience, found herself unable to manage the dire situation that unfolded before her eyes. Blood flowed, and a cord prolapse added urgency to an already critical scenario. With a sense of urgency, Tapenensi was whisked away to Malongo HCIII.

In the critical moments that followed, a beacon of hope emerged in the form of an ambulance summoned by the Emergency Transport Program under Bulamu Healthcare. Two midwives accompanied the ambulance, racing against time to transport Tapenensi to Mayuge HCIV. The journey became a lifeline, a thread connecting the distressed mother to the possibility of salvation.

Upon arrival, Dr. Mike, the medical officer at Mayuge HC IV, faced a harrowing decision. He had to choose between saving the mother or the lifeless baby. In a somber moment, he approached Tapenensi's husband, delivering the devastating news of a stillborn child. Consent was urgently sought to prioritize saving the grieving mother, engulfed in excruciating pain.

Heartbreak loomed as Tapenensi's husband began preparations for an immediate burial, following the cultural norms of their Moslem community. The shroud for the lifeless infant lay close, ready to envelop what would have been a new and hopeful existence.

Yet, just when despair threatened to claim the day, Dr. Mike's voice echoed through the corridors of the health facility. "Midwives, we have a life to save," he proclaimed. A flicker of hope ignited as the medical team rallied to rescue Tapenensi from the clutches of tragedy. A 1.2 kg baby miracle was born, care extended to the Neonatal care Unit.

In the midst of exhaustion and emotional turmoil, Tapenensi, a first-time mother, emerged victorious. Her premature miracle, born two months early, defied the odds and thrived against all expectations. The intricate dance of life and death had left an indelible mark on her and her family, but the innovative interventions of Bulamu had smoothed the tumultuous journey.

Bulamu, under its flagship Maternal and Child Health (MCH) program, continued to revolutionize healthcare in the region. Neonatal Intensive Care Units (NCUs) became integral parts of Health Center IVs, transforming them into havens for fragile lives. The program not only established these vital units but also trained and mentored healthcare workers across five districts, creating a ripple effect of improved care for preterm babies.



In the regions of Busoga, Northern Uganda, Rwenzori, and the Southwestern territories, Bulamu's commitment to "Helping babies survive" manifested in the setup, equipping, and functionalization of neonatal care units. The once bleak landscape of neonatal survival now bore the marks of a turning point, as Bulamu's innovations breathed life into the fragile beginnings of countless newborns.



Transforming Neonatal Care: Bwera Hospital's Journey to Saving Lives

TRANSFORMING NEONATAL CARE: BWERA HOSPITAL'S JOURNEY TO SAVING LIVES.

(By Sr. Doreen Mbabazi)

Bwera Hospital, a government-aided district hospital situated in Mpondwe Lhubiriha Town Council, Kasese District, plays a pivotal role in providing healthcare support to not only its immediate surroundings but also the neighboring districts of Bunyangabu, Rubirizi, and parts of the Democratic Republic of the Congo (DRC).

Supported by Baylor and UNICEF, this district hospital has recently undertaken an inspiring transformation in its neonatal care unit, a significant milestone in the endeavor to save the lives of sick newborns and low birth weight (LBW) babies.

The inception of the neonatal care unit in January 2020 was born out of a pressing need.

Bwera Hospital recognized that the sick newborns and LBW babies were not receiving appropriate care. Consequently, many were being referred to Kagando Hospital, which had a Neonatal Unit. However, a significant percentage of these infants returned home due to concerns about the medical costs associated with the referral. Sadly, many LBW and sick newborns met an untimely demise within their communities.

Transforming Neonatal Care: Bwera Hospital

The neonatal unit at Bwera Hospital had modest beginnings, with just one incubator, one oxygen concentrator, and two hospital beds housed in a small room within the maternity ward. The unit was initially supported by midwives working in maternity and one nurse. Although the number of admissions was limited in the beginning, concerted efforts to raise awareness about neonatal services resulted in a rise in admissions, with referrals coming in from lower health centers. Despite a reduction in referrals out, extremely low birth weight babies were still being referred to Kagando Hospital due to the lack of incubators and expertise in preterm management.

Acknowledgment goes to the hospital administration for arranging for Sr. Doreen Mbabazi's training at Kagando Hospital, where she acquired skills in newborn management. Additionally, Baylor Uganda's facilitation of national mentors in Newborn care, led by Dr. Margaret Nakakeeto, played a crucial role. With their mentorship, the neonatal unit at Bwera Hospital was equipped with the skills and knowledge needed to manage extremely LBW babies and severely asphyxiated infants. The hospital administration's allocation of dedicated staff to work in the Neonatal unit was another essential step in the right direction.

A significant turning point was reached with UNICEF's generous donation of equipment for the Neonatal unit, including incubators, monitors, infusion pumps, baby warmers, CPAP machines, phototherapy machines, and an automated generator, among others. These contributions have revolutionized the unit's ability to manage sick newborns and extremely LBW babies effectively, leading to a reduction in neonatal deaths and referrals out. With an increasing number of clients seeking care at the unit, a larger space was allocated within the pediatric ward to admit sick newborns.

However, the unit still faces challenges, including inadequate human resources and the need for more mentorship programs at lower health centers. Late referrals continue to be a problem, resulting in a high mortality rate among these referred infants.

However, the unit still faces challenges, including inadequate human resources and the need for more mentorship programs at lower health centers. Late referrals continue to be a problem, resulting in a high mortality rate among these referred infants.

In closing, the unwavering commitment and collaborative efforts of Bwera Hospital, Baylor Uganda, UNICEF, and various other stakeholders have significantly improved neonatal care. Their relentless dedication and advocacy have even led to the impending construction of a new Neonatal unit by the Japanese embassy. This promising development underscores Bwera Hospital's commitment to saving lives and ensuring a brighter future for the tiniest and most vulnerable members of their community.



The New NICU Building at Bwera Hospital, a Gift from the Japanese Embassy, Promising a Brighter Future for Preterm Infants.

EXPLORING EXCELLENCE: THE POWER OF INTERFACILITY EXCHANGE VISITS.

In the heart of Kampala metropolitan, Uganda, a transformative initiative called the Saving Women and Preterm Babies project (SWAP) is unfolding. This four-year collaboration supported by Save the Children in partnership with the Ministry of Health (MOH), Kampala Capital City Authority (KCCA), and Vayu Global Health Foundation, is driven by a collective mission to improve maternal and neonatal health outcomes.

Uganda faces preventable maternal and neonatal mortality challenges, largely stemming from complications like haemorrhage, hypertensive disorders, infections, and preterm birth. Within Kampala, which comprises over 20% of the urban population, perinatal death rates are notably high, especially in the realm of early neonatal deaths. SWAP seeks to fortify maternal and newborn care through five health facilities in the Kampala metropolitan area including Wakiso HCIV, Mukono General Hospital, Kisenyi HCIV, China Uganda Friendship Hospital, and Kawaala Health Center IV. Its multifaceted approach aims to enhance the identification and management of pregnancy complications leading to preterm birth, and to elevate care for small and sick newborns. This collective endeavour reflects a commitment to bolstering essential services, shaping a brighter path for the most vulnerable lives.

Project Objectives:

- Strengthen the identification and management of complications potentially leading to preterm birth in supported health facilities.
- Enhance care for all newborns and manage preterm labor within supported health facilities.
- Elevate facility-based care for small and sick newborns.
- Utilise data-driven quality improvement processes to inform decision-making for improved care.

At the heart of SWAP's strategy lies a focus on health worker training and mentorship. Master Trainers, drawn from project facilities, champion the dissemination of expertise across maternal and newborn care. This cascade training approach encompasses essential programs like Helping Babies Survive and Helping Mothers Survive, tailored to address various aspects of neonatal and maternal care.

The project provides and uses cutting-edge technologies to enhance care and improve survival of small and sick newborns, including:

- ◆ Bubble Continuous Positive Airway Pressure (bCPAP) devices: high-quality, low-cost oxygen delivery systems offering respiratory support for infants and children. This is an affordable system that requires no electricity or compressed air and is easy to use and maintain. The devices delivers blended Oxygen to the babies and reduces the possibility of retinopathy of prematurity.

Exploring Excellence: The Power of Interfacility exchange visits.

- ◆ **NeoNatalie Live Training Application:** a smart-skills training application with simulation equipment that empowers health workers through simulation-based resuscitation training.

The Saving Women and Preterm Babies project stands as a testament to collaboration, innovation, and compassion. With a focus on strengthening maternal and neonatal care, SWAP endeavours to rewrite the narrative of maternal and neonatal health outcomes, creating a legacy of improved well-being for Uganda's future generations. Part of the knowledge and learning programs under the SWAP program includes the power of learning from peers through the interfacility learning visits.

Overview:

The project undertook the exchange learning visits over a period of four weeks between June and July 2023 with the aim of facilitating knowledge exchange and collaboration among healthcare workers from 05 participating facilities of Wakiso HCIV, Mukono General Hospital, China Uganda Friendship Hospital-Naguru, Kawaala HCIV and Kisenyi HCIV. This initiative was organized to harness collective expertise and experiences in order to improve the care of mothers and newborns across the facilities.

In each week, 3 staff per facility (1 from maternity, neonatal unit, antenatal care unit) was facilitated to visit and blended in the duty shifts in the hosting facilities for a period of 03 days. The visiting health workers worked during the day shifts and shared knowledge and at the end of the activity had to document best practices, what did not go well, and areas of improvement in the respective units. Best practices were adopted and lessons shared through a reflection meeting with the respective facilities.

Goals: The primary goals of the interfacility learning visit were as follows:

- ◆ **Knowledge Exchange:** To share best practices, innovative approaches, and clinical insights among healthcare professionals.
- ◆ **Capacity Building:** To enhance the skills and competencies of healthcare workers by exposing them to diverse clinical settings and experiences.
- ◆ **Quality Improvement:** To identify areas for improvement in patient care, infection control, and healthcare processes.
- ◆ **Collaboration:** To foster collaboration and networking among healthcare professionals, promoting a sense of shared responsibility for regional healthcare.

Key Areas of Focus: During the visit, the healthcare workers from different facilities focused on the following key areas:

Clinical Protocols: Participants had the opportunity to compare and evaluate clinical protocols and guidelines implemented at their respective facilities. This included discussions on best practices in diagnosis, treatment, and patient management.

Infection Control: Special attention was given to infection control practices, with a particular emphasis on preventing healthcare-associated infections. Participants shared strategies for reducing infection rates and improving hand hygiene compliance.

Exploring Excellence: The Power of Interfacility exchange visits.

Patient-Centered Care: Healthcare workers explored strategies for providing patient-centered care, including effective communication with patients and their families, and promoting a compassionate approach to healthcare

Resource Management: The visit included discussions on optimizing resource allocation, including staffing, equipment, and pharmaceuticals, to ensure efficient and cost-effective healthcare delivery.

Data Collection and Reporting: Participants exchanged insights on data collection and reporting systems, aiming to standardize documentation practices and enhance data-driven decision-making.

Emergency Response and pre-referral management: A key focus was placed on emergency response and pre-referral management protocols, ensuring that healthcare facilities were well-prepared for various contingencies.

In the interim, there were quick gains from the facilities that adopted the best practices from the facilities visited. Wakiso HCIV was able to strengthen the care in their newly functionalized newborn care unit and reducing unnecessary referrals to Kawempe National Referral Hospital, BABIES matrix has been adopted as well as the monthly dashboard of the metrics as well as the care forms and protocols from the facilities visited. Some the actions are to be implemented in the long term due to resource constraints. There is need to have these more frequently to include the facility data teams and the impact evaluated overtime because of the 2-way learning system.



THE FIRST SET OF TRIPLETS SURVIVES AT MOYO GENERAL HOSPITAL

(Authors :Wasswa C, Pipeline Worldwide, Bessy, Palorinya HCIII, Abio Rose)

Poni Harriet is a mother of 2 live boys a before the triplets, having attended Antennal twice, Poni Harriet was hoping to do her ultra sound scan for the first time during her next visit as scheduled. At 30 weeks of gestation Poni Harriet on 7/02/2023 at around 8:00am started feeling labor like pains that she didn't take serious since her date of birth was not yet, at 3:00 pm labour like pain intensified that she immediately rushed to the Palorinya HCIII in the settlement to seek for health care. Being reviewed at the health facility by the midwife, findings showed she was previous scar with an over distended abdomen, since ultra sound scan was note done it was hard to suspect she had triplets. The midwife made a decision to refer the mother to a higher facility that is Moyo general hospital.

On arrival to the facility at 5:00pm mother was already in second stage of labor with no indication of multiple pregnancies, but the attending midwife suspected multiple pregnancy since the mothers abdomen was over distended and on auscultation there were fetal heart sounds heard on both sides.

At 5:20pm the first twin was delivered she was a cephalic presentation with a score of 8 at (1 minute) and 10 at (5 minutes) weighing 1100grams baby girl, at 5:45 pm the second twin is delivered since it presented in breech with a score of 4 at (1 minutes) and 6 at (5 minutes) weighing 1000grams baby girl, positive pressure ventilation was provide until the preterm (2nd twin) picked up at 10 minutes.

The preterm were immediately rushed to the NICU for advanced care since they were too small.

The attending midwife did not have it in mind or suspect that there was a third baby left and on attempting to deliver the placenta by palpation and vaginal examination she confirmed it was not the placenta it was another baby still left in the uterus .Having taken a lot of time to realize this the attending midwife ruptured the membranes and delivered the 3rd twin at 6:20pm with a score of 1 (1 minutes) at 3 at (5 minutes) with a birth weight of 1200 grams baby boy, the 3rd twin only had the cord pulsating. The skilled midwife was able to provided positive pressure ventilation, chest compression registering progress and improvement initiating breathing and later baby was taken to the NICU for advanced care since they were informed about the preterm coming through to them.

In the NICU the babies were well received but since all the incubators where being occupied by other preterms the only option was to manage them on the radiant warmer ,put on continuous positive air way pressure (CPAP)since all were in severe respiratory distress. Fluids and medications were given to them.

On the 3rd day the 1st and 2nd twin were being able to taken off oxygen therapy and feeding was initiated on the 2nd day since they showed signs of tolerance to the feeds .The 3rd twin still on CPAP with signs of improvement as we hope he will be off oxygen soon since reports show good results.

The First Set of Triplets survives at Moyo Gen. Hospital

The mother remains great full for the support rendered to her by the hospital team towards her baby and dedicates herself to ensure her babies are feed every 3 hours as prescribed by the staff daily, in the process she has learnt and accepted the out comes as being a first time for her. Having the triplets in the unit it gave us an opportunity to lobby and request for more support in terms of equipment, so request were made to have more incubators.

Pipeline wide which had installed for us a solar system capable of running all the crucial equipment's in the NICU on 14th/November/2022 was able to respond to our request.

In 3 weeks pipeline worldwide was able to ship in 2 brand new incubators for our NICU Moyo General, on 3rd/03/2023 the two incubators were installed and moved into the NICU for use and the triplets being the first beneficiaries from it since the mother was practicing intermittent KMC . AVSI foundation also responded to our request by providing us with one more incubators making a total of 4.

The mother of the triplets was educated and taught on how to practice kangaroo mother care (KMC) and feeding them by cap. She would rap two babies at once then other would be done later alternatively while in the incubators.

Coupled with the stress with the mother not having a care taker the triplets were put for intermittent KMC in the incubator, progressively the triplets started gaining weight. Through the existing team work with the lower facilities a follow up with the family members was made to ensure that some can be sent to support her while in the hospital as was becoming tedious for Poni to do all by herself.

In 1month 3/52weeks the triplets had gained 1597g, 1400g, and 1350g on 31/03/2023 gaining weight at 25g/day/kg.

With support from AVSI in the establishment of KMC corners, and mentorships on kangaroo mother care putting emphasis on follow up clinics through linkage with the lower health facilities triplets were linked to Palorinya HCIII to register them in the follow up register and link them to the nutritional department since her breast milk was not enough.

Through the follow-up linkage with the lower health facilities through palorinya HCIII through a whats app group created for Obongi district for the newborn has been able to provide us feedback on the progress of the triples on a weekly basis by accessing for weight gain, head circumference, KMC practice, feeding and report any danger signs identified if any. By the second week the triplets were 2000 grams for the boy and 1700grams, 1900 grams for the girls respectively.

With support from the AVSI the NICU team was able to do a follow up home visit with the help of the VHT joyful it was to see the triplets incorporated with there family member growing.

As of now the triplets are gradually gaining weight, this has been attributed to the knowledgeable and skilled NICU team in educating the mother of how to take care of her triplets inclusive of KMC,feeding , identifying danger signs and feeding problems being able to be supported by the Nutritional department ,a good relationship and team work with the lower facilities most importantly the follow ups at lower facilities with timely feedback not forgetting our partner and friend Pipeline worldwide for the solar power which has proved so vital in the operation of the NICU in case of black outs of power with other equipment donated.



Figure 1 the triplets in the incubator



Figure 2 the triplets in the incubator



Figure 3 Poni practicing Kangaroo Mother Care after feeding the triplets



Figure 4 A home visit to Poni with the triplets



Saving Women and Preterm Babies' Project (SWAP)

Experience in the use of the Vayu Bubble CPAP in selected health facilities in the Kampala Metropolitan Area

(By Sandra Nnabulime, Dr. Douglas Akiibua, Racheal Auma, Andrew Oola, Nicholas Mbowa, Trevor Biransesha, Violet Birungi)



With support from an anonymous donor, Save the Children International is implementing the Saving Women and Preterm Babies project (SWAP) to improve the quality of care for pregnant women (particularly those likely to deliver premature/small babies), and small and sick newborns (SSNBs). This is being delivered through institutionalization of evidence-based lifesaving interventions in a network of five health facilities in the Kampala Metropolitan Area (Kisenyi Health Center IV, Kawaala Health Centre IV, Naguru Hospital, Wakiso Health Centre IV and Mukono General Hospital).

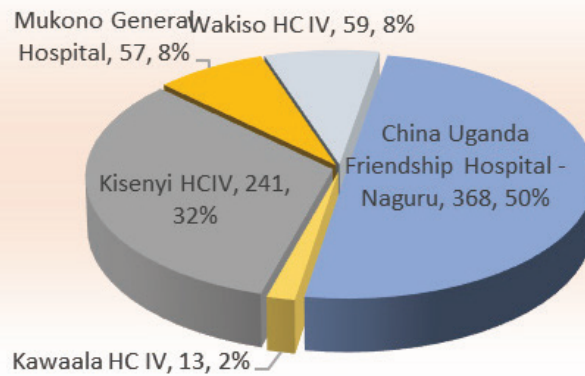
The major causes of neonatal deaths in Uganda like in other Sub-Saharan African countries include sepsis/pneumonia, tetanus, diarrhea, prematurity, and birth asphyxia. This hence prompted a project that would focus on improving the quality of care for mothers (particularly those likely to deliver premature/small babies), and small and sick newborns by supporting delivery and institutionalization of evidence-based lifesaving interventions in a network of five health facilities in Kampala, that are linked to one tertiary level health facility.

Saving Women and Preterm Babies' Project (SWAP)

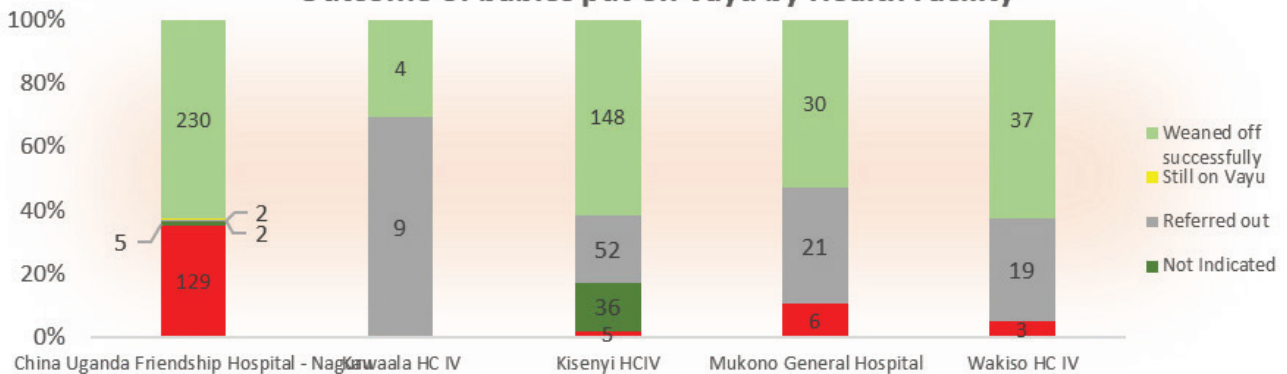
The project was introduced and is currently implementing 3 new technologies: (1) The Vayu CPAP (an ultra-low-cost, easy to use, portable system to address respiratory distress in neonates and infants); (2) The PRISMS application (a comprehensive clinical decision support platform that brings expertise to the bedside while gathering data to guide system-level interventions) with newly developed algorithms to accompany project interventions; and, (3) the NeoNatalie Live (A Newborn Ventilation simulator, a 'smart' and affordable simulator that collects data and provides objective feedback to health workers on improving and maintaining skills and decision-making for neonatal resuscitation).

World Prematurity Day, observed every year on November 17th, is a time to raise awareness about the critical issue of premature birth and its impact on the lives of babies and their families. It is also an opportunity to celebrate the advancements in medical care that help premature infants thrive. One such remarkable innovation is the Vayu Bubble CPAP (Continuous Positive Airway Pressure) an ultra-low-cost, easy to use, portable system to address respiratory distress in neonates and infants and has transformed the outcomes for premature babies. So far, the SWAP project has had a total of 738 babies initiated on Vayu and an overall survival rate of 65%. The figures below show the outcomes of babies put on vayu;

Total number of babies put on CPAP per Facility



Outcome of babies put on Vayu by Health Facility



Premature birth, defined as birth before 37 weeks of pregnancy, is a global health issue. Babies born prematurely often face various health challenges due to their underdeveloped organs, particularly their lungs. The respiratory system of preterm infants is not fully mature, making it difficult for them to breathe independently. This is where the Vayu Bubble CPAP steps in; the Vayu Bubble CPAP is a high-quality newborn and infant bCPAP system that does not require electricity, medical compressed air, or manual power. It is a non-invasive respiratory support therapy that delivers a continuous flow of air to a baby's airways, helping to keep their lungs open and prevent them from collapsing. This technology is administered through a small mask or prongs placed in the baby's nose. The pressure supplied keeps the air sacs in the lungs open, enabling better oxygen exchange and reducing the effort required for breathing.

Benefits of the Vayu Bubble CPAP for Premature Infants

Administration of blended Oxygen: The Vayu Bubble CPAP therapy ensures that the baby receives adequate oxygen, which is vital for the development of various organs, including the brain while ensuring that the amount of oxygen given is regulated.

Reduced Need for Invasive Ventilation: CPAP can often prevent the need for more invasive mechanical ventilation, which can have its own set of risks.

Decreased Respiratory Distress Syndrome (RDS): RDS is a common respiratory condition in premature infants. CPAP can reduce the severity and duration of RDS.

Lower Risk of Long-term Complications: Using CPAP effectively early on can lower the risk of long-term respiratory issues and other complications.

Promotion of Kangaroo Care: CPAP therapy can often be administered while practicing kangaroo care, enabling parent-infant bonding and skin-to-skin contact.

Progress with the Vayu Bubble CPAP

For a period of 14 months, across all five project supported facilities, we have had more than 738 babies benefit from the Vayu Bubble CPAP of which 44% of these were preterm babies.

Celebrating Progress on World Prematurity Day

World Prematurity Day is an occasion to celebrate the advancements in neonatal care, including the use of CPAP, that have significantly improved the survival and long-term outcomes of premature babies. This technology has made it possible for many preterm infants to breathe more easily and transition into life outside the neonatal units more smoothly.

Healthcare professionals, parents, and caregivers all play a vital role in ensuring the success of CPAP therapy for premature babies. Proper training and education are essential to understand the equipment and monitor the baby's progress.

Healthcare professionals, parents, and caregivers all play a vital role in ensuring the success of CPAP therapy for premature babies. Proper training and education are essential to understand the equipment and monitor the baby's progress.

Saving Women and Preterm Babies' Project (SWAP)

The project was introduced and is currently implementing 3 new technologies: (1) The Vayu CPAP (an ultra-low-cost, easy to use, portable system to address respiratory distress in neonates and infants); (2) The PRISMS application (a comprehensive clinical decision support platform that brings expertise to the bedside while gathering data to guide system-level interventions) with newly developed algorithms to accompany project interventions; and, (3) the NeoNatalie Live (A Newborn Ventilation simulator, a 'smart' and affordable simulator that collects data and provides objective feedback to health workers on improving and maintaining skills and decision-making for neonatal resuscitation). World Prematurity Day, observed every year on November 17th, is a time to raise awareness about the critical issue of premature birth and its impact on the lives of babies and their families. It is also an opportunity to celebrate the advancements in medical care that help premature infants thrive. One such remarkable innovation is the Vayu Bubble CPAP (Continuous Positive Airway Pressure) an ultra-low-cost, easy to use, portable system to address respiratory distress in neonates and infants and has transformed the outcomes for premature babies. So far, the SWAP project has had a total of 738 babies initiated on Vayu and an overall survival rate of 65%. The figures below show the outcomes of babies put on vayu;

In conclusion, the Vayu Bubble CPAP represents a powerful tool in the fight to improve neonatal care, reduce infant mortality, and enhance the quality of life for premature babies. By advocating for its adoption and wider use, we can make a tangible difference in the lives of these fragile infants and their families. Let us work together to save lives and promote healthier beginnings for our youngest generation.



For more information on this, please reach out to Sandra Nnabulime, Health Specialist, Sandra.nnabulime@savethechildren.org
Save the Children Central Region Office



Save the Children

(By Waliggo Henry S (Newborn Steering Committee))

AN EXTRAORDINARY YEAR: CELEBRATING DR. MARGARET K NAKAKEETO'S COMMITMENT TO NEWBORN HEALTH

Dr. Margaret Nakakeeto Kijjambu stands as an accomplished consultant neonatologist and pediatrician, with a wealth of experience in diverse healthcare settings. Her contributions have been instrumental in establishing and enhancing newborn care units, elevating the capabilities of healthcare professionals to provide top-tier care for sick and preterm infants.

She serves as the Chair of the National Newborn Steering Committee of the Ministry of Health in Uganda. Her visionary leadership spearheaded the formulation of a comprehensive roadmap titled "Creating Responsive and Sustainable Systems for Newborn Survival," setting a clear vision for Uganda's newborn care.

Dr. Margaret's influence extends beyond vision setting. She actively engages with district and facility leadership, ensuring the practical implementation of the WHO newborn standards across the country. Driven by a commitment to improve neonatal care, she has played a pivotal role in training frontline healthcare workers not only in Uganda but also in the broader East African region.

The recognition of Dr. Margaret's contributions reached a new height on November 10, 2023, when she was awarded the prestigious title of Doctor of the Year in the Maternal and Child Health Care category from HIHA Uganda. In addition, on October 24, 2023, she received an award from the American Academy of Pediatrics. It's undeniably a remarkable year for Dr. Margaret, marking her significant impact on healthcare.



Dr. Margaret and Dr. Yvonne holding their Prestigious Awards from the American Academy of Pediatrics

Under her leadership, the National Newborn Steering Committee transformed discontent into an action. Dr. Margaret actively challenges healthcare professionals to move beyond dependence on external support. She leads by example, providing essential materials and resources where needed and instilling a powerful motto: "Do not wait for American dollars to develop."



Dr. Margaret proudly holding her HIHA Doctor of the Year award, beaming with joy."

Her commitment extends beyond administrative roles. She has been known to personally involve herself in the improvement of healthcare facilities. In instances where cleanliness falls short, she and her team roll up their sleeves, with Sr. Damalie, a committee member, exemplifying a commitment to cleanliness that goes beyond expectations.

A notable incident speaks volumes about the impact of their work. During an assessment of maternal and child health services in a certain district, Dr. Margaret's team encountered an exceptionally dirty health center. After a thorough cleaning, locals mistook them for a professional cleaning company, a testament to the transformation they brought about.

“

Her commitment extends beyond administrative roles.

Dr. Margaret, affectionately referred to as "Maama Newborn" by those she has influenced, has successfully lobbied for numerous districts. Her advocacy has borne fruit in the form of new NICU buildings at Bwera Hospital and Kamuli Hospital, Mukono GH NCU, Wakiso HCIV NCU, Sekanyonyi HCIV NCU in Mityana district, and many more, with no signs of slowing down.

A special acknowledgment is extended to the Newborn Steering Committee members, Richard Businge, Agnes Kirikumwino, Damalie Mwogererwa, Juliana Kemirembe, Charles Walulya, Henry Waliggo, Margaret Namawanda, Justine Nakiyinjji, Dr. Aisha Gimbo, and Dr. Jessica Nakibuuka, alongside the backing of Dr. Migadde Deogratias and Assistant Commissioner Reproductive and Infant Health Dr. Mugahi Richard, have played a crucial role.

In conclusion, heartfelt gratitude is expressed to the inspiring individuals propelling this transformative journey. Dr. Margaret's steadfast commitment to newborn health remains evident. As appreciation is conveyed to the National NBSC and all supporters, there is anticipation for a future where doctor's passion sparks continued positive change. With her resolute spirit and the collaborative efforts of an exceptional team, confidence is expressed in achieving even greater strides in neonatal care. Dr. Margaret not only celebrates past achievements but is poised for new ventures that will shape the landscape of newborn health for years to come. Thank you all.

For God and my country.

Benchmarking Mother-newborn Care Units In India

NOVEMBER 2023

By Adara Development

UGANDA WORLD PREMATURETY DAY

A key pillar of Adara Development's work is knowledge sharing. Adara believes in the value of learning and collaborating with others to make our work stronger.

Because of this priority area, in September, doctors and nurses from Kiwoko Hospital and staff from Adara Development Uganda travelled to India for a benchmarking visit. India is known as a global trailblazer in maternal and newborn healthcare in low-resource settings.

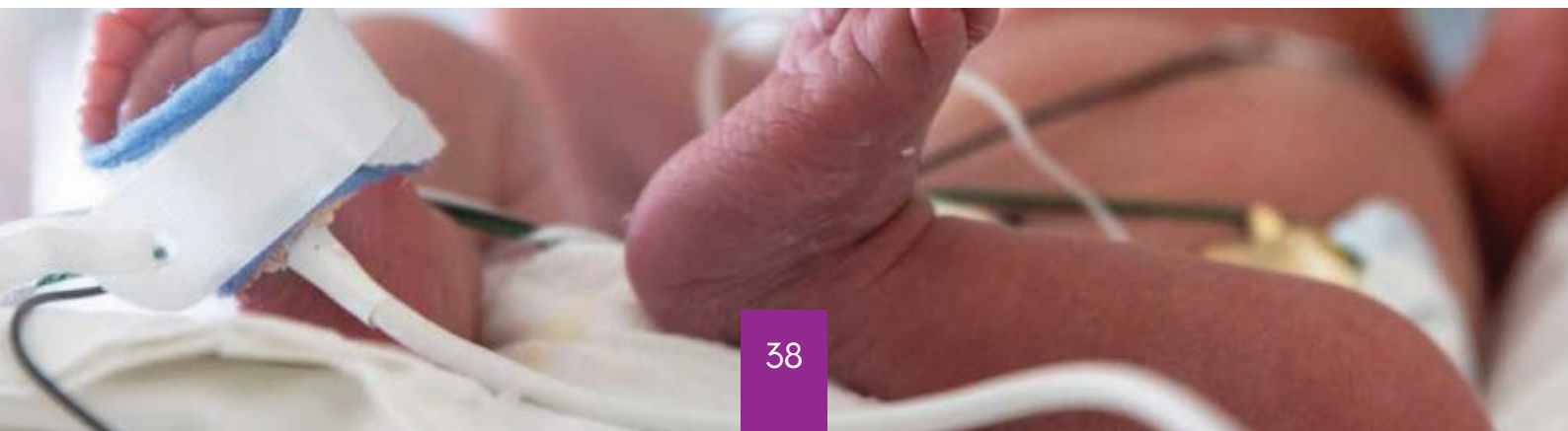
Sick and small newborns are typically provided specialised medical care separate from their mother. WHO is supporting this new model of care in which sick and small newborns are not separated from their mothers but cared for together from birth until discharge. India is leading global implementation and research into these mother-newborn care units (MNCU).

Adara's Maternal, Newborn and Child Health programmes emphasise family centred care, which means the family plays an essential role in the care of their baby. Families have early involvement from the time the baby is admitted to the newborn unit, sharing decision making and acting as a respected member of the care team. An MNCU promotes family centred care by creating an environment where the family is involved in the care of their baby 24 hours a day. This is shown to increase confidence and the ability to care for their baby after discharge.

"There are many benefits of a mother-newborn care unit," states Hilda Namakula, Adara's Uganda Clinical Educator. "Having the mother stay with the baby allows for immediate and prolonged kangaroo mother care and there is often a better milk supply for breastfeeding due to the mothers constantly holding their babies. There are also benefits to hospital staff as it reduces nurses' non-essential clinical work as this is now carried out by the mother and mothers can learn from each other in the unit."

There were several takeaways that the team are integrating into their work, ensuring that every mother and newborn receives the highest quality care. For the MNCU to work, there needs to be strong collaboration between maternity and newborn providers and ensuring there is appropriate space available. The unit requires around the clock coverage by a specialised doctor. Appropriate staffing that considers the nurse to care for both the mother and the baby is necessary, as well as a plan for escalating emergency care when needed. Lactation and breastfeeding support should be provided from day one. The main takeaway is that MNCU is a feasible and valuable model of care.

Adara is considering how to incorporate this model of care into our work at Kiwoko Hospital and the facilities in which we work.





The team receive a tour of the NICU at All India Institute of Medical Science



The mother-newborn care unit at Kalawati Saran Children's Hospital, India



Nurturing Hope: The Power of Breastfeeding and Breast Milk Donation in Premature Babies' Lives

Introduction:

The emotional toll of prematurity is profound. Parents find themselves balancing between the excitement of a new life and the uncertainty of their child's health. Feelings of guilt, anxiety, and helplessness are common companions on this journey. It's a testament to the strength of families that, despite these challenges, they continue to provide unwavering love and support to their preterm infants.

According to the World Health Organization, prematurity is when a baby is born alive before 37 weeks of pregnancy are completed. This unexpected entrance into the world introduces a set of unique challenges for both infants and their families. These challenges can range from medical complexities to emotional and financial strains, requiring a resilient spirit to navigate this uncharted territory.

Among the various support systems available, breastfeeding emerges as a powerful ally in nurturing preterm infants.

The Miracle of Breastfeeding:

Breast milk is a natural gift that not only fosters a strong bond between mamas and their babies but also provides essential nutrients crucial for a baby's development. For premature babies, this becomes even more critical. Breast milk is tailor-made to meet the unique needs of preterm babies, offering a perfect blend of nutrients and antibodies that protect them against infections and illnesses.

Premature babies often face challenges in their early days, and breast milk acts as a healing elixir. It aids in the development of their fragile immune systems, promotes faster weight gain, and reduces the risk of complications. The emotional connection formed during breastfeeding also provides a sense of comfort and security for these tiny warriors.

Breast Milk Donation – A Lifesaving Act:

In the face of these challenges, community support and awareness play a pivotal role. Understanding the unique needs of preterm infants and their families fosters empathy and compassion. It encourages the creation of supportive environments in healthcare settings, workplaces, and public spaces, acknowledging the daily battles these families face.

Not every mama can breastfeed, and some preterm babies may not have access to their own mama's milk. This is where the incredible act of breast milk donation comes into play. Mamas who produce more milk than their baby needs can donate their surplus milk to milk banks. These banks ensure that preterm infants, whose mamas may be unable to provide sufficient milk, receive the nourishment they need for a healthy start in life.





Benefits of Breast Milk Donation:

Life-Saving Nutrition: Donated breast milk provides preterm infants with a lifeline of essential nutrients, promoting healthy growth and development.

Immunological Support: The antibodies present in breast milk strengthen the immune system of premature babies, protecting them from infections.

Emotional Connection: Just as with breastfeeding, receiving donated breast milk fosters a sense of emotional connection and well-being for preterm infants.

Mama's Health: Studies have revealed that breastfeeding has benefits for mama too, as it lowers the risk of developing certain cancers.

How Breast Milk Donation Works:

Screening: Donor mamas undergo a thorough screening process to ensure the safety and quality of the donated milk.

Collection: In a milk bank, the donated milk is carefully collected, stored, and pasteurized to eliminate any potentially harmful bacteria while preserving its nutritional value.

Distribution: The processed milk is then distributed to neonatal intensive care units (NICUs) and directly to families with premature infants in need.

Informal milk sharing: In some places with no access to breast milk banks, breast milk sharing has been successful, especially in the presence of family and friends. Here, donors should be carefully tested for disease-causing pathogens that might transfer through the milk.

How You Can Contribute:

Raise Awareness: Share information about prematurity beyond special awareness weeks. Encourage open conversations about the challenges faced by families dealing with prematurity.

Support Organizations: Contribute to or volunteer with organizations dedicated to prematurity awareness, breastfeeding support and breast milk banking. These organizations often provide resources, emotional support, and financial assistance to affected families. In Uganda, you can get more information about hospital-based milk donation from some private hospitals, Nsambya Hospital and Mbale Regional Referral Hospital, and community-based donation at ATTA Breastmilk Community.

Policy work: Advocate for policies that prioritise the importance of breastfeeding, the well-being preterm infants and their families, ensuring access to quality healthcare and financial assistance.



LIST OF CHAMPIONS

NAME	PLACE OF WORK	DISTRICT
Businge Richard	Newborn Steering Committee	Kampala
Waliggo Henry	Newborn Steering Committee	Kampala
Musubika Esther	Bayitambogwe HCIII	Mayuge
Bewayo Kevin	Wabulungu HCIII	Mayuge
Nabirye Hajara	Masorya HCIII	Mayuge
Cherop Doreen Toskin	Bayitambogwe HCIII	Mayuge
Naigoma Falida	Jaguzi HCIII	Mayuge
Nakamate Lilian	Busala HCIII	Mayuge
Neirima Jane	Bukatube HCIII	Mayuge
Nabirye Irene	Malongo HCIII	Mayuge
Kasirir Fatuba	Bugulu HCIII	Mayuge
Mirembe Catherine Oliva	Kigandalo HCIV	Mayuge
Namulondo Sylvia	Kigandalo HCIII	Mayuge
Kirabo Maureen	Bukatube HCIII	Mayuge
Katuwo Frances	Kigandalo HCIII	Mayuge
Namwase Mariam	Kigandalo HCIII	Mayuge
Kabara Edward Mangeni	Malongo HCIII	Mayuge
Adong Filda	Malongo HCIII	Mayuge
Mpawatetwa Malita	Nkombe HCIII	Mayuge
Nangobi Esther	Wabulungu HCIII	Mayuge
Aliwayatya Florence	Kityerera HCIV	Mayuge
Mpawaliba Rosemary	Mayuge HCIV	Mayuge
Nakimera Nzirani Timarwayo	Buwaiswa HCIV	Mayuge
Adikini Charity	Sagitu HCII	Mayuge
Nakayenga Resty	Bugoto HCII	Mayuge
Nkangu Milly	Mayuge HCIV	Mayuge
Kauma Jennifer	Bwonda HCII	Mayuge
Wambale James	Busaala HCIII	Mayuge
Naula Stella	Mayuge HCIV	Mayuge
Aurumo Dinah	Buyugu HCII	Mayuge
Mbeiza Sarah	Kityerera HCIV	Mayuge

NAME	PLACE OF WORK	DISTRICT
Agutu Florence	Wandegeya HCII	Kampala
Bilungi Martha	Kityerera HCIV	Kampala
Kadondi Roset	Muggi HCII	Mayuge
Tiberimbwaku Teddy	Buwaiswa HCIII	Mayuge
Namugaya Evelyn	Mayuge HCIV	Mayuge
Naigaga Judith	Nabisoigi HCII	Budaka
Babirye Lydia	Kagulu HCIII	Budaka
Nanyinji Christine	Bulange HCIII	Namutumba
Kabushera Richard	Nsinze HCIV	Namutumba
Konso Tabisa	Ivukula HCIII	Budaka
Katono Norah	Bulange HCIII	Budaka
Gonza Zerida	Magada HCIII	Namutumba
Nairuba Sarah	Namuwondo HCII	Budaka
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Okello Abraham	Nsinze HCIV	Namutumba
Alinganyira Prossy	Ivukula HCIII	Budaka
Nakadama Rehema Abiba	Namutumba HCIII	Namutumba
Bambi Elizabeth Betty	Magada HCIII	Namutumba
Naigaga Eva	Ivukula HCIII	Budaka
Kampi Hasifa	Nabisoigi HCII	Budaka
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Nampandu Cliff	Budaka HCIV	Budaka
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Adiam Anna Beatrice	Kebula HCII	Budaka
Obore Sandra	Sapiri HCIII	Budaka
Kagoye Edinansi	Kameruka HCIII	Budaka
Namusabi Hamba Zabiya	Budaka HCIV	Budaka
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Mutaki Winnie	Budaka HCIII	Budaka
Lagose Grace	Katira HCIII	Budaka
Musede Stephen	Katira HCIII	Budaka
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Mukyala Faith	Kaderuna HCIII	Budaka

NAME	PLACE OF WORK	DISTRICT
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Nampewo Dorothy	Kisiita HC III	Kakumiro
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Atuhura Lilian	Igayaza HC III	Kakumiro
Nakyeyune Margret	Birembo HC III	Kakumiro
Adong- Kena Janet	Igayaza HC III	Kakumiro
Ayikoru Vivian	Kakumiro HC IV	Kakumiro
Nakibuule Rosemary	Kasambya HC III	Kakumiro
Busobozi Nasta	Kasambya HC III	Kakumiro
Nyamahunge Judith	Nalweyo HC III	Kakumiro
Nakato Grace Mary	Kakindo HC III	Kakumiro
Kunihira Christine	Kakindo HC III	Kakumiro
Bujuni Margret	Kisiita HC III	Kakumiro
Basasibwaki Lydia	Kisengwe HCIII	Kakumiro
Namuyiga Sarah	Kakumiro HC	Kakumiro
Asaba Moureen	Kakumiro HCIV	Kakumiro
Nyamaizi Rosette	Kisengwe HC III	Kakumiro
Kagona Juliet	Birembo HC III	Kakumiro
Kasabiti Imelda	-	Kyegegwa
Komuhimbo Alice	-	Kyegegwa
Ahabyona Bernadate	-	Kyegegwa
Arinaitwe Provas	-	Kyegegwa
Kobusingye Sarah	-	Kyegegwa
Niwenshaba Irene	-	Kyegegwa
Kakuze Nuriat	-	Kyegegwa
Kabahinda Grace	-	Kyegegwa
Ngonzi Rose	-	Kyegegwa
Kemigisa Stella	-	Kyegegwa
Kemigisa Yustez	-	Kyegegwa
Kyomuhimbo Beatrice	-	Kyegegwa
Abagarulira Jacinta	-	Kyegegwa
Mbambu Gloria	-	Kyegegwa
Kabasomi Jackline	-	Kyegegwa

Mugidde Esther	-	Kyegegwa
Katuutu Proscovia	-	Kyegegwa
Katusiime Priscilla	-	Kyegegwa
Byabona Doreen	-	Kyegegwa



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“Small Actions, BIG IMPACTS: Immediate skin-to-skin care for every baby everywhere.”

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