Headlights

Highlights

Scientists support use of HIV drug linked to birth defects in babies ................................................................. 2
Why Tanzania offers huge potential for drug-makers .............................................................................................. 4
Tanzania: Over 40pc of Children Under Five Don't Use Medicated Nets ............................................................... 8
Health ministry: Triple polio doses were meant to cover 'loophole' ................................................................. 10
Tanzania: 80pc Tanzanians to Have Access to Health Insurance by 2020 - Government ................................. 12
Born neither male nor female, a tale of raising an intersex ............................................................................. 13
Tanzania: Bugando Now Overwhelmed By Children with Anorectic Malformation ........................................... 16
Witness links ex-pathologist Njue to missing body organ .................................................................................. 17
Can Rwanda be the blueprint for delivering primary health care? ..................................................................... 18
Why it takes a degree of insanity to be a surgeon at Mulago Hospital ............................................................. 20
KCPE candidate gives birth, writes tests at Kwale Hospital ............................................................................. 23
FEATURED: FAGACE, Coqebanque ink deal to finance pharmaceutical plant - Rwanda ............................... 24
Government names best, worst hospitals - Uganda .............................................................................................. 26
Government questions high rate of C-section births ......................................................................................... 27
CANCER WARRIOR: A bundle of joy in the middle of gloom .......................................................................... 28
Uganda confirms case of Crimean-Congo fever near DRC border ................................................................... 31
WFP calls for more effort to end hunger, malnutrition ..................................................................................... 33
Scientists support use of HIV drug linked to birth defects in babies
October 28, 2018
By Daily Nation

Dolutegravir (DTG) has very few side effects and is easier to take (one small tablet, containing three drugs, taken once daily).

In Summary

- The Health ministry in July asked counties to stop prescribing DTG to HIV-positive women.

- But the scientists said the decision to ban the drug was arrived at without outweighing the benefits and risks of dolutegravir (DTG) in women living with the virus.

- Dr. Sharon Hiller from the University Of Pittsburg, US, said there was no data to confirm that the drug was risky and banning it was patriarchal.

- Dr. Michelle Moorhouse of Wits University in South Africa, said it is a tricky situation since dolutegravir is a great drug, and for those women who are using effective contraception, it remains a great option

MADRID, SPAIN,

Researchers have warned countries against stopping the use of a drug linked to birth defects in HIV-positive women.

They said the decision to ban the drug was arrived at without outweighing the benefits and risks of dolutegravir (DTG) in women living with the virus.

NO DATA

Presenting different papers on the drug at the third international HIV and Aids conference on research for prevention in Madrid, Spain, the researchers said there is need for a full picture of antiretroviral safety across the lifespan of women before an action is taken.

Dr. Sharon Hiller from the University Of Pittsburg, US, said there was no data to confirm that the drug was risky and banning it was patriarchal.

"With the position taken by most countries, it clearly says that women must just take what they are given and that don't have a voice to choose. We are robbing the women off choices. It is fault protection; it is patriarchal. We need to stop," she said during a presentation on striking a balance.
The Health ministry in July asked counties to stop prescribing DTG to HIV-positive women.

This was after a warning from the international regulators, US Food and Drugs Administration and the European Medicines Agency.

**EFFECTS**

Studies had shown that women with HIV taking the drug at the time of conception or during the first trimester of pregnancy appear to be at higher risk of giving birth to babies with neural tube defects.

Neural tube defects in babies can occur early in pregnancy when the spinal cord, brain, and related structures do not form properly during the first trimester.

Director of Medical Services Jackson Kioko directed county health directors to ensure that expectant and breastfeeding mothers to whom a front-line drug had been prescribed, continue their current prescription until they stop breastfeeding.

But those of childbearing age of between 15 and 49 years, who are on the drug, should be given the first-line treatment Efavirenz.

"I advocate for women to be told the risk in a clear way that can be understood to decide for themselves. If they cannot tolerate a drug, then they should be placed on another. If she goes off treatment to become pregnant because of the rare birth effects, she is risking her life and the baby," Dr. Hiller said.

**BALANCE**

When asked to compare the benefits versus risks of the drug, she noted the good outweigh the bad.

She urged HIV-positive women not to be afraid of the rare effects and instead ensure they take treatment that they can tolerate and stick to.

She asked countries to strike a balance between risks and benefits of women having healthy children.

Dr. Michelle Moorhouse of Wits University in South Africa, said it is a tricky situation since dolutegravir is a great drug, and for those women who are using effective contraception, then it remains a great option.

"I have to say this is an early signal, which we need to take seriously, but we have seen similar signals before with other drugs, which over time turned out not to be the problem we anticipated," she said.

She added there are a number of other studies underway which could clear up the link and potentially clear dolutegravir’s association with this serious potential side-effect.

““The benefits of the drug, including the fact that it has shown no development of resistance in any patients should not be overshadowed by this “signal”. I really do want to caution against panic,” she said.
Why Tanzania offers huge potential for drug-makers

OCTOBER 28, 2018

By The Citizen

The deputy minister of Health, Community Development, Gender, the Elderly and Children, Dr. Faustine Ndugulile, addresses participants in the Health Supply Chain Summit 2018 in Dar es Salaam early this month

In Summary

- WHO, United Nations Comtrade and Business Monitor International show that the pharmaceutical market grew to $450m in 2017 from $107m in 2007.

Dar es Salaam. Tanzania’s pharmaceutical market is forecast to grow to $700 million by 2021, up from $450 million in 2017.

The World Health Organisation, the United Nations Comtrade and Business Monitor International show that the pharmaceutical market grew to almost $450 million in 2017 from $107 million in 2007.

It grew by $47 million, down from the expected $497 million.

The forecasts were revealed last week by an industrial engineer in the Ministry of Industry, Trade and Investment, Dr. Yuda Benjamin, during a two-day Health Supply Chain Summit that brought together over 200 participants.

In his presentation titled ‘Fostering private sector engagement to improve availability of health commodities in Tanzania’, Dr Benjamin said the sector was projected to grow by $35 million in 2018 to $532 million from $497 million in 2017.

“Projected growth is partly because of the government’s efforts to promote industrial growth so as to realise the country’s strategy to become a middle-income economy by 2025,” he said.

According to him, revenue generated by pharmaceutical industries will increase when investments are raised. He noted that the products of local industries are traded domestically. The sector’s contribution to the gross domestic product (GDP) is projected to be one per cent by 2021, down from 1.04 per cent in 2017.

“The country’s GDP keeps on increasing annually that is why it decreases even when revenue from the sector increases. Massive investment in the sector will increase the
sector’s contribution in terms of GDP by 2021,” he told The Citizen.

He said by 2021 the Ministry of Health would spend 17.8 per cent of its budget on purchasing pharmaceuticals, down by 0.2 per cent from 18.00 per cent in 2017.

By 2021, Tanzania’s health spending is expected to be $3.908 billion, up from $2.765 billion in 2017.

He also spoke about government transformations in phasing the public sector out of production activities and encouraging the private sector to become the engine of the country’s economy. “Strategies are also provided for implementation of the Sustainable Industrial Development Policy, or SIDP, under the current business environment and extend it to 2025.”

He said the government had been implementing the 13-year Integrated Industrial Development Plan since 2012 whose objectives include improving the manufacturing sector, increasing its contribution to the GDP, raising revenue after value addition and exporting more goods.

According to him, while the manufacturing sector is expected to grow by 6.6 per cent from 8.4 per cent to 15 per cent annually, its contribution will increase from 6.59 per cent to 23 per cent by 2025.

“The sector will generate $16.8 billion by 2025 and that the export of manufacturing goods will be valued at $6.6 billion by 2025.”

Tanzania has 14 registered domestic pharmaceutical industries, 11 of them producing human medicines, two making veterinary medicines and one facility manufacturing health devices.

Most of them produce a narrow range of products, mainly generics.

According to him, the country lacks facilities to produce Active Pharmaceutical Ingredients, packaging manufacturing industries and industries to manufacture excipients.

Experts define excipients as substance formulated alongside active ingredients of a medication, included for the purpose of long-term stabilisation, bulking up solid formulations that contain potent active ingredients in small amounts (thus often referred to as “bulking agents”, “fillers”, or “diluents”), or to confer a therapeutic enhancement on the active ingredient in the final dosage form, such as facilitating drug absorption, reducing viscosity or enhancing solubility.

Dr. Benjamin gives a list of non-medical supplies which are among the country’s opportunities for potential investors in the pharmaceutical sector to satisfy demand of the Medical Stores Department (MSD). The department also buys medicines for Southern African Development Community (SADC) countries in a new deal.

They include the manufacture of safety boxes for disposable used syringes, bed-
sheets, packaging boxes, dispensing envelopes, colour-coded waste bins, prescription forms (A5), patient registers, injection registers, ball-point pens, and many others.

The government has formulated a list of medicines and medical equipment that could be produced locally instead of importing them.

On the list are Paracetamol tablets & syrup, Co-trimoxazole tablets & syrup, Amoxycillin capsules & syrup, Ciprofloxacin tablets, Erythromycin tablets & suspension and Penicillin VK tablets & Syrup.

Others are Quinine tablets & syrup, Ampicillin+Cloxacillin capsules & syrup, Metronidazole tablets/suspension and Artemether+Lumefantrine tablets & syrup.

According to him, Tanzania’s geographical location simplifies export of products to neighbouring countries. It shares its borders with eight countries, and this is likely to attract investors who will have a large market for their products.

Moreover, Tanzania’s population has been growing rapidly population.

There is a prevalence of diseases and the presence of MSD as the bulk procurer and the availability of the national health insurance scheme.

“The country imports 89 per cent of medicines, 100 per cent of medical devices and manufactures 11 per cent of all pharmaceuticals. The situation makes it favourable for investors,” he said. He spoke about 17 companies that have expressed their intentions to invest in the sector.

They include Biotech Limited, Novabi Limited, Tabora Textiles Limited, Zinga Pharmaceuticals Limited, Guilin Pharmaceuticals (T) Limited, Simiyu Project and Bahari Pharmacy Limited.


MSD director general Laurean Rugambwa told The Citizen over phone that the department had been spending $800 million on purchasing medicines and medical equipment annually. He noted that the country had a huge potential for investors who met two criteria.

According to him, pharmaceutical companies should produce medicines and medical equipment that meet international standards and that they should be sold at reasonable prices.

“We, at MSD, are not obliged to spend our funds on providing manufacturers with subsidies. We are supposed to ensure value for money is realised. “Investors in pharmaceutical industries are lucky that the MSD market has expanded after we have
signed a contract to procure medicines for the Southern African Development Community countries and that the ball is now in their court.”

Pharmaceutical Management and Supply Chain programme coordinator Emilian Ng’wandu said technology development, vibrant human resources and better policies were key for the country to build sustainable industries.

He said poor technology negatively impacted local manufacturers to meet required standards of medicines. It also affected the ability of the companies to produce large quantities of medicines.

He explained that while the country was facing a shortage of skilled human resources, policies governing the sector hindered efforts of building a sound pharmaceutical sector.

“The government should create an enabling environment for pharmaceutical companies to operate through use of local and imported technologies. Human resources should be trained at different levels to serve the sector,” he said.

“Policies and laws governing institutions such as the Tanzania Bureau of Statistics, the Tanzania Food and Drugs Authority and respective industries should be harmonised to avoid overlapping of activities.”

In his recent column titled ‘What it takes for re-birth of Tanzania’s drug sector’ in The Citizen, Dr. Omary Chillo, underscored the need for a strong political will.

He expressed his confidence that President John Magufuli’s statement that Tanzania needed major reforms in the local pharmaceutical sector was a starting point.

When officiating at an MSD event, Dr Magufuli was quoted as saying “only 6 per cent of the medicines used in the country are produced locally. Why? We must do something…”

According to Dr. Chillo, despite the President’s political will, the road to achieving a well-established local drugs industry requires a collective responsibility between the public and private sector.

“I would like to borrow the point of view of a report released in 2016, titled ‘Pharmaceutical Manufacturing Decline in Tanzania: How Possible Is a Turnaround to Growth?’ It actually said, it requires a change of mind-set for policy makers in Tanzania to prioritise and actively engage in selective support of the sector,” read part of his column.

But, Sikika director Irenei Kiria told The Citizen over phone that budget constraints, bureaucracy, poor infrastructure in supply chain and inadequate pharmaceutical experts were major challenges facing the country.

He clarified that while the government was confident of allocated budget (Sh270 billion) for purchase of medicines, not all the funds
were disbursed and the amount provided was not released on time.

According to him, the government has been hoarding the purchase and distribution of medicines and medical equipment, causing bureaucracy in the sector and leading to citizens’ complaints about the shortage of drugs. “Regarding infrastructure, the government should formulate sustainable plans to ensure more Lorries are bought annually to replace wrecked ones and reduce donor dependence in strengthening infrastructure,” he said. “Pharmaceutical experts should also be increased to enhance efficiency. The government should address the acute shortage of experts.” Dr. Chakou Halfani said stressed the need for prioritisation of research on medicinal plants to ensure a strong healthcare system.

He said the country should heavily invest in research to see how extracts from various medicinal plants can be used or developed into pharmaceutical drugs.

“Tanzanians, by their nature, are used and interested in traditional medicine. “We all understand that most pharmaceutical products that are in the market have been developed from some indigenous plant species. But unfortunately, most drugs we use here are imported. Can Tanzania manufacture its own drugs from the variety of plant species that are in the country?” he questioned in his recent article published in The Citizen.

Speaking during the meeting, the deputy minister of State in the President’s Office (Local Government and Regional Administration), Mr. Josephat Kandege, and said Tanzania spent Sh1 trillion on purchasing health-related supplies annually, but only 10 per cent of the products were purchased locally.

“The private sector has a huge untapped potential because medicines and medical equipment currently supplied on the market are below demand,” he said.

Tanzania: Over 40pc of Children Under Five Don't Use Medicated Nets
29 OCTOBER 2018
Tanzania Daily News (Dar es Salaam)

About 46 per cent of children below five years are at high risk of contracting malaria in Mainland Tanzania because they don't
sleep under insecticide treated nets (ITNs), a new survey shows.

Although children and pregnant women are particularly at high risk of contracting the deadly disease, the newly released 2017 Tanzania Malaria Indicator Survey (TMIS) concludes that only 54 per cent of children under the age of five in Mainland Tanzania sleep under ITNs.

Countrywide, the findings released last week, revealed that just a night before the survey was conducted, only 55 per cent of children below five years slept under ITNs both in Mainland Tanzania and Zanzibar.

However, the findings suggest that only 54 per cent of children below five years in Mainland Tanzania slept under ITNs the night before the survey compared to 67 per cent in Zanzibar.

This means that in Mainland Tanzania about 46 per cent of children below that age are at high risk of contracting the disease if immediate measures are not taken by the Ministry of Health, Community Development, Gender, Elderly and Children. Presenting survey findings, National Bureau of Statistics (NBS) Departmental Manager for Social and Demographic Statistics Stephano Cosmas said in total 9,724 households were selected for the 2017 TMIS of which 9,390 were successfully interviewed at the time of fieldwork, yielding a total household response rate of 99 per cent and the sample design, which provides estimates at national level, urban and rural areas, Mainland Tanzania and Zanzibar, for nine zones and for 31 regions," he said.

As regards the use of ITNs, Mr. Cosmas said significant strides had been made in the prevention of malaria through the use of ITNs, thus reducing malaria transmission from 14.4 per cent in 2015 to 7.3 per cent in 2017.

The 2017 TMIS includes questions on bed net ownership, use and type of net. Overall, 78 per cent of households in Tanzania own at least one ITN and households in urban areas are more likely to own an ITN (81 per cent) than households in rural areas (77 per cent).

Despite the ownership of ITNs, the findings further assess the number of people, who sleep under the nets. Overall, over half of the household population in Tanzania (52 per cent) slept under an ITN the night before the survey.

However, the results on the use of ITNs by children, who have high chances of contracting malaria were not promising, according to Mr. Cosmas.

Ideally, among other issues, the primary objectives of the 2017 TMIS are to measure the level of ownership and use of mosquito nets and assess coverage of intermittent preventive treatment for pregnant women.

Others are to identify treatment practices, including the use of specific anti-malarial medications to treat malaria among children between six and 59 months, to measure the
prevalence of malaria and anaemia among children aged six and 59 months and assess knowledge, attitudes and practices among women aged between 15 and 49 years.

**Health ministry: Triple polio doses were meant to cover ‘loophole’**

**OCTOBER 29, 2018**

By Daily Nation

A child is being immunised against polio at Hagadera Refugee Camp in Dadaab on September 15, 2018

**In Summary**

- The third round of the vaccine campaign targeted 12 counties and ended on Wednesday, last week.
- The campaign was initiated after the discovery of live polio samples in Nairobi’s Eastleigh area in March.
- The latest campaign has been blighted by severe reaction by a four-year-old girl who developed sores after being given the polio vaccine.

The Health ministry has cited precaution as the reason behind the recent multiple campaigns against polio, where children in 12 counties have received up to three doses in quick succession.

Many parents have been wondering why their children have had to receive oral doses within days of each other.

Now Afya House headquarters, Nairobi, officials say it is because they wanted to be sure that all the children have been immunised.

**PROTECTION**

Dr. Daniel Langat, the head of disease surveillance at the Health ministry, said Kenyans had no reason to worry about the multiple doses being given to children, adding that it was aimed at maximum coverage.

“When you receive a vaccine for the first time, it is not absolute that you will get immunity or protection against the respective disease targeted,” he said. He explained that this was because vaccines do not always enable the bodies of immunised people to build up protection with just one dose.

**POPULATION**

“The efficacy or ability of vaccines to offer protection is at around 85 percent. This means that for every 100 people we
vaccinate, 85 will develop protection from the first dose but the other 15, whom we may not know, will not,” he said. Dr. Langat gave this as the reason behind the multiple doses given to children under five years. “The more times you give the vaccine, the more certain you will be that you have covered the target population.”

ANALYSIS
The third round of the vaccine campaign targeted 12 counties and ended on Wednesday. Sponsored by the United Nations Children’s Fund (Unicef) and the World Health Organisation (WHO), the campaign targets immunising 2.8 million children under five years in Kiambu, Kajiado, Kitui, Isiolo, Meru, Machakos, Wajir, Busia, Mandera, Tana River, Lamu and Nairobi counties.

According to Dr. Langat, the campaign was initiated after the discovery of live polio samples in Nairobi’s Eastleigh area in March. “Our immunisation campaigns are based on quarterly risk analysis.

INFECTION
This year, we selected the 12 counties seen to be at greatest risk of polio infection,” said Dr. Langat.

He added that counties bordering Ethiopia and Somalia were included in the campaign since the last 14 known cases of the virus were reported as having crossed into Kenya from the north.

The latest campaign has been blighted by severe reaction by a four-year-old girl in Nairobi’s Kahawa West, who developed sores after being given the polio vaccine last weekend.

SAMPLES
“Countries that lie in the migratory path from Somalia — like Kitui and Isiolo — also had to be included in the campaign, as there is a lot of movement of people across the border into these areas. Nairobi also made it to the list as the samples had been discovered in Eastleigh, in addition to adjacent counties like Machakos and Kiambu,” said Dr. Langat.

The latest campaign has been blighted by severe reaction by a four-year-old girl in Nairobi’s Kahawa West, whose scary photos have been doing the rounds on social media platforms.

According to the girl’s aunt, Ms. Jane Gichuki, she developed sores after being given the polio vaccine last weekend.

REACTION
When they went to hospital on Monday, last week, she said, the family was informed that it was a reaction to the immunisation, and that even if it looked severe, the benefits of being immunised far outweigh the side effects.

On Sunday, Ms. Gichuki said the infection had spread to the girl’s one-year-old sister, even as they were gauging the effectiveness of medication given for the sores.

Dr. Langat said the vaccines are safe, adding that they had been tested stringently before
being introduced into the country’s healthcare system.

HARMFUL
“Before we introduce any medication or vaccine, it must be subjected to stringent testing by our National Quality Control Laboratory, the manufacturers’ laboratories as well as international bodies like WHO and others. There is no way the government would willingly allow harmful medication or vaccines to be dispensed to its people,” he said.

Tanzania: 80pc Tanzanians to Have Access to Health Insurance by 2020 - Government
29 OCTOBER, 2018
By Tanzania Daily News (Dar es Salaam)

In a bid to ensure 80 per cent of Tanzanians have access to health insurance by 2020, the government has expanded its services through the Community Health Fund (CHF) across the country.

The Health Promotion and System Strengthening (HPSS), which is funded by the Switzerland-based Swiss Agency for Development and Cooperation (SDC) plays a big role in enabling CHF members to have health services at any health centres country-wide, as well as expand the scope of services.

CHF released nearly 100m/- for the implementation of a health programme in Dar es Salaam, including training sessions to potential CHF members’ registrars expected to be at their work stations next month.

The HPSS Chief Technical Support Adviser Ally Kebby said Tanzanians were required to pay only 40,000/- each and 150,000/- for a sixmember household for a year.

"People should visit their local government offices to be informed of where registration centres are located. Registrars are also trained to educate members of the public about the importance of joining health insurance schemes, which are prepaid services.

The target is to register 1.8 million people in the region," he stressed.
Born neither male nor female, a tale of raising an intersex

OCTOBER 29, 2018
By Daily Monitor

Shamira Namaganda with her child Mercy Namayanja. Namaganda is hopeful that one day her child will have the necessary surgery to enable her live a normal life.

In Summary

- SIPD now advocates for the ‘best guess’ non-surgical approach where an intersex child should be raised in the best-suited gender, without irreversible surgical intervention because only the affected person can decide whether to take on these risks.

- This can be done when the child is old enough to participate in the decision-making process and when they have also shown more features of either sex.

“The doctor told me that I had delivered an intersex baby and after explaining to me what this meant, he advised me to take it to Mulago National Referral Hospital for surgery. To say I was shocked is an understatement. I did not know whether my child would survive,’’ Shamira Namaganda recalls.

It was joy when 24-year-old Namaganda and her husband Ibrahim Waiswa, residents of Buyengo village, Tome Sub-county in Buvuma District, welcomed their baby girl, Mercy Namayanja on April 4, 2015. Namaganda delivered by cesarean section at Kawolo Hospital in Buikwe District and both parents were eager to meet their bundle of joy. Although this joy was short-lived, the couple purposed to stay together and look after their child.

What it means

Intersex, or differences of sexual development (DSD), is an umbrella term that refers to people born with variations in sex characteristics that do not fit into the typical binary definition of boy or girl. Although some parents may have heard of this term, many who find themselves in a similar situation are shocked to realise that babies can be born with anything other than a penis or vagina.

“She has a very tiny hole from where she urinates a condition described by doctors as Clitoromegaly (an enlarged clitoris). The clitoris continues to grow because when she was born, it was small. She does not have all complete characteristics of female private
parts or that of a male,“ Namaganda explains.

Stigma

Namaganda says she is currently in fear of her child being ridiculed because of her condition.
“When I am bathing her, I make sure that no one sees her private parts because I do not want her to become a laughing stock. Some of my neighbours know about her condition and I worry that they will spread the news to other people who will make my child feel out of place,” Namaganda says adding that her friends have advised her to take the child to a traditional healer because they believe she was bewitched while still pregnant.

Medical report

Findings after medical examination of the child from ECOS Imaging Centre in Wandegeya, Kampala on November 30, 2017 signed by Dr. Nobert Katongole, a radiological officer, indicate that the child is a female Pseudo-hermaphroditism.

“A small uterus is visualised, two ovaries are seen, the urinary bladder appears normal, no testicular is observed and the glands and kidneys appear normal. Findings are of urogenital sinus malformation [commonly associated with the urethra and vagina opening in one aperture] and suggests female Pseudo-hermaphroditism,” the report reads in apart.

In a medical letter dated January, 24, 2018, doctors from Mulago National Referral Hospital where the baby was referred, recommended surgery.

Experts speak

Dr. Paul Kaduyu, a gynecologist/Obstetrician, says a baby may develop two sexual organs due to mother’s exposure to chemicals or drugs which contains male or female hormones.
“The condition may develop if during the early stages of pregnancy the mother is exposed to chemicals such as those found in some of the lotions we use and drugs, especially those which have male or female hormones,” he says.
Dr. Kaduyu adds that sometimes genetic mutation [genetic disorder] may occur during the formation of an embryo.
“In this case where it is a mistake in the genes that the embryo may develop without certain critical organ that defines a male or female. These are people you find when the uterus did not develop, the vagina did not develop and a person looks female with everything but when you check, there is no vaginal opening but with a very tiny opening which passes urine and an elongated clitoris,” he says.

Dr. Angella Namala, an Obstetrician/gynecologist from Jinja Regional Referral Hospital, urges parents with children who have ambiguous genitalia to take them for examination in order to know whether the child is genetically male
or female.
“Especially for female with ambiguous genitalia they have along clitoris and a closed vaginal, sometimes when it was a mistake in the growth, they have testicular which produces male hormones. It is very important while screening these children to find out where these testicular tissues exist so that they can be removed,” she says. Dr. Namala adds: “Testicular tissues behave in a way that if it is at abnormal temperature, it can easily become cancerous so they must be removed.”
She says chances of such a female child with ambiguous genitalia to have children in future are low but a surgery on the genitalia must be conducted to make the baby more female or male. Dr. Fahad Muyomba, a pediatrician at Whisper’s Magical Children’s Hospital in Jinja, says the cause of intersex condition is not known but genital reshaping surgery can be done successfully.

Research
According to August 2015 survey by the Support Initiative for People with Congenital Disorders (SIPD), an intersex health and rights organisation, Uganda does not have a laboratory to perform chromosomal tests for children to help determine sex and genital reshaping surgeries are often flawed. It indicated that a few surgeries have been attempted to alter ambiguous genitalia in infancy but most of these have been unsuccessful and the intersex children have ended up developing physical characteristics of the opposite sex at puberty.

The survey also indicated that Most intersex children in Uganda are assigned female at birth and raised to identify as women, but for many intersex women, female biological milestones, such as menstruation and breast development do not necessarily follow. Instead, some are faced with changes associated with male puberty, such as beard growth, body hair and voice deepening.
A large number of intersex adults are dissatisfied with the results of childhood genital surgery; the study authors recommends that surgical decisions be postponed until adolescence or adulthood, when the patient can give informed consent.
After realising that performing genital reshaping surgery on intersex children at birth or soon after is harmful, Uganda Parliament issued guidelines in 2015 to the Ministry of Health advising against surgical intervention for intersex infants.

Complications
According to Medical researchers, genital reshaping surgeries often do not work out as planned. They can cause lifelong physical and psychological pain, scarring, lost sexual sensation, ridicule and stigma, which can lead to suicide attempts and higher rates of school drop-out. Sometimes the procedures also involve involuntary sterilisation.
SIPD now advocates for the ‘best guess’ non-surgical approach where an intersex child should be raised in the best-suited gender, without irreversible surgical intervention because only the affected person can decide whether to take on these risks.
This can be done when the child is old enough to participate in the decision-making process and when they have also shown more features of either sex.

**Financial constraints**

However, Namaganda says she cannot afford to pay for the surgery since the doctors told her that if the genital reshaping surgery is to be conducted in India or US, it will cost Shs50m and Shs10m at Mulago. “Government phased out nursing assistants in hospitals yet it is the course I had pursued. Currently, I do not work because a number of hospitals will not accept my certificate. My husband, a maize vendor, cannot raise the money needed too,’’ she says.

**Statistics**

According to Support Initiative for People with Congenital Disorders, at least three children are born with an intersex condition at Mulago National Referral Hospital, every week.

However, the condition affects up to 1.7 percent of the world’s population according to the United Nations.

**Tanzania: Bugando Now Overwhelmed By Children with Anorectic Malformation**

30 OCTOBER, 2018

By Tanzania Daily News (Dar es Salaam)

The Bugando Medical Centre (BMC) is receiving an incredible number of children with anorectic malformation as it lacks paediatric surgeons to attend to them.

Speaking to reporters at the weekend, the BMC acting director of surgical services said more than 50 patients were referred to the BMC every year, while more than 200 were being attended at a special clinic.

According to Dr. Massenga, 10 patients have undergone an operation procedure called posterior sagittal anorectoplasty (PSARP) thanks to visiting medical experts from Belgium, who come every year to help perform surgical services.

Malformation is a birth defect that affects the development of the anus, while it also affects the urinary or reproductive system and its structures.

Heart, kidney, limb, spine and oesophagus defects have also been associated with
PSARP. "Until Friday, 12 experts in collaboration with local experts performed successful operations to 10 children out of more than 200 in need of the service," she said.

Dr. Massenga was of the view that local surgeons could attend to patients, but since they were not specialised in paediatric surgeries they could do it with limitations, especially when it came to attending to special cases accompanying the malformation.

She was, however, hopeful that while BMC was building capacity to train its own paediatric surgeons, which would in the next two years improve the situation, at least two local doctors were expected to graduate.

The high cost of training paediatric surgeons is probably one of the reasons behind the current shortage with Dr. Massenga saying that about $13,000 (27m/-) was needed to train a single surgeon per year, which amounts to 81m/- for the entire three year programme per surgeon.

Commenting on the matter, Dr. William Kahabi, a general practitioner at BMU and who has been attending to patients with anorectic malformation, said many of the referred patients came from regions with mining activities.

He cited Mara and Geita as some of the regions with many referrals with initial findings showing that anorectic malformation was caused by exposure to heavy metals like mercury largely found in mining activities undertaken by small-scale miners.

"Normally, this malformation affects children whose parents are greatly exposed to metals like mercury and there is no solution in sight if this mining practice will not change," he cautioned.

A team leader of the medical experts from Belgium, Dr. Lingier Pierre, said they would always be ready to assist in treating patients suffering from the problem through cooperation between BMC and his country.

**Witness links ex-pathologist Njue to missing body organ**

**OCTOBER 30, 2018**

By Daily Nation

Former government pathologist Moses Njue when he appeared before a court in Nyeri on May 16, 2018
In Summary

- Mr. Mwongela added that the second report indicated that two body parts were missing: the heart and kidney.

- The case will resume on February 19.

The organ theft case against former government pathologist Moses Njue took a dramatic turn after a key witness said Dr. Njue confessed to stealing a heart.

Advocate Charles Mwongela, whose father Benedict Karau was buried without a heart, told a court in Meru that it was after the second autopsy that Dr. Njue allegedly confessed to stealing the body part.

"Chief Government Pathologist Johansen Oduor told us that Dr. Njue had confessed that he took the heart. When I asked him where the heart was, he said he cannot remember where he kept it; whether in a private medical hospital in Nyeri or Consolata hospital where he conducted the first post-mortem. He said he would make it available in two weeks, but he did not do so," Mr. Mwongela told Chief Magistrate Hannah Ndung’u.

SECOND POST-MORTEM

The post-mortem was done because they were not satisfied with the initial one conducted to establish the cause of death.

“The first autopsy was conducted by Dr. Njue and Meru Level Five pathologist Scholastica Kimani on March 12, 2015 at Consolata Hospital in Meru,” he said.

The body was exhumed five months later for the second examination carried out at Meru Funeral Home by a team consisting of Dr. Oduor, Dr. Sylvester Maingi, Prof Kiama, Dr. Scholastica Kimani and Dr. Njue.

“After the exercise, Dr. Oduor told us that apart from injuries on the head, he had other injuries that were not indicated in the first post-mortem report, like elbows with defensive wounds. The first autopsy had only indicated that he died from a heart attack,” he said.

Mr. Mwongela added that the second report indicated that two body parts were missing: the heart and kidney.

But during cross-examination, he said, he could not confirm the claim. Dr. Njue also denied committing the offence. Mr. Mwongela said he had been receiving reports that his father had been killed.

“I was told he choked with food when he was taking dinner. That reason did not satisfy me because when my brothers went to view the body at Meru Level Five mortuary, they said it had bruises.”

The case will resume on February 19.

Can Rwanda be the blueprint for delivering primary health care?

30 October, 2018
By Githinji Gitahi - Amref Health Africa

As Rwanda’s case demonstrates, it is possible for even a low-income country to
provide publicly financed, quality health services to all

Githinji Gitahi is Group CEO of Amref Health Africa and Global Co-Chair of UHC2030.

Twenty years ago, I was a young doctor trying to make a difference in my local community in Nairobi, Kenya. Back then, child mortality rates were much higher, and it was not uncommon for children to die because of lack of access to basic immunisations, medicines or procedures. The child mortality rate in sub-Saharan Africa has dropped by more than **50 percent since 2000**, and nothing has been more gratifying than seeing those numbers reflected in the lives of healthier children in my own community – and across the continent.

Improvements in primary health care over the past two decades have been key to this progress, but this trend is far from universal. While some countries, such as Rwanda, Ghana and Ethiopia, have made impressive strides in strengthening health systems and expanding coverage, others, such as Equatorial Guinea and South Sudan, have fallen behind. There is a great deal that we can learn from countries like Rwanda that have been prioritising primary health care to achieve quality, affordable health coverage for all their citizens.

Rwanda has made primary health care a cornerstone of its expansion of health services – as a matter of principle, but also of economic necessity. After all, approximately **90 percent** of a person’s health care needs across his or her lifetime can be covered by primary health care, which is much more cost-effective than hospital-based care. Primary health care is where people turn for routine check-ups, where children access immunisation, where mothers receive prenatal and postnatal care, and where signs and symptoms for illnesses can be caught before they evolve into life-threatening conditions. Rwanda’s primary health care system also integrates services to address the leading causes of mortality in the country, which has led to drastic reductions in deaths from diseases like HIV, tuberculosis and malaria over the past several years.

Rwanda’s recognition of health care as a means to treat all people with dignity and also improve productivity is part of a growing global movement. In 1978, in Almaty, Kazakhstan, health experts and world leaders made a commitment to promote access to health care in their countries with the groundbreaking **Declaration of Alma-Ata**, reaffirming the principle that health is a fundamental human right. This October – 40 years later – world leaders have come together once again in Kazakhstan for the **Global Conference on Primary Health Care** to endorse a new declaration, emphasising the critical role that primary health care plays in improving lives around the world.

As we reflect on these commitments and the remarkable progress that countries like Rwanda have made, we must also remember that much remains to be done – locally, regionally and globally. Countries from the US to India to South Africa can learn from
Rwanda’s dramatic progress toward ensuring primary health care services reach the poorest and most marginalized – from funding and supporting health workers to political will at the highest levels of government to drive reforms. Rwanda will showcase its health systems roadmap at the Africa Health (AHAIC) 2019 global summit next March, so that other countries can learn from it how to build a health system that is fit for purpose to deal with the ongoing threat of pandemic outbreaks, growing drug resistance, and the increasing burden of cancer, diabetes, and other chronic diseases.

As Rwanda’s case demonstrates, it is possible for even a low-income country to provide publicly financed, quality health services to all, especially if those services are delivered through primary care. Achieving universal health coverage in Africa is an ambitious goal, but it is not an impossible one – the time to roll up our sleeves and get to work is now.

**Why it takes a degree of insanity to be a surgeon at Mulago Hospital**

**OCTOBER 30, 2018**

By Daily Monitor

---

**In Summary**

- **Independent review.** Beyond celebrating the newly renovated hospital building, the executive and legislative branches of the Uganda government have an urgent duty to act on Dr. Manyirlirah’s concerns. The place to start is a thorough and independent external review of Mulago Hospital, with a view to making necessary radical changes.

By Why degree insanity surgeon Mulago Hospital

Dear Tingasiga;

When Dr. Joseph Buwembo, an Associate Professor of Neurosurgery at the University of Saskatchewan, Canada, visited Uganda in 2012, his mission was not only to see his relatives and enjoy his homeland, but also to give back to his people. He offered free neurosurgery on a baby that had a very complex brain problem. This would help that baby and teach skills to younger colleagues.
With this offer, Mulago and Makerere Medical School were getting the best of the best, for Dr. Buwembo is one of the most highly educated neurosurgeons around. A graduate of Makerere Medical School, Kampala, Dr. Buwembo qualified as a neurosurgeon in South Africa before relocating to Canada in 1996. He underwent another four years of training in neurosurgery and became a Fellow of the Royal College of Surgeons of Canada in 2000. He is an Associate Professor of Surgery at the University of Saskatchewan, Canada.

Prior to arriving in Kampala in 2012, Dr. Buwembo had made arrangements to commence the operation on the baby at 7.30 am on the appointed date. However, when he and his Canadian team of nurses arrived at Mulago National Referral and Teaching Hospital, they found that there was no anaesthetist to put the baby to sleep and manage her heart and breathing during the extremely delicate procedure. There was no explanation given and there was no other anaesthetist to do the job. The baby, her family, Dr. Buwembo and his team simply waited, in the dark so-to-speak.

When the anaesthetist showed up at 10am, he appeared unperturbed by the delay and simply informed the team that he had been busy attending to his parent who was unwell. Dr. Buwembo and his team proceeded with the surgery, which lasted three and half hours. The team then spent another hour speaking with the parents and accompanying the baby to the post-operative unit. Needless to say, the team’s other engagements were disrupted. The compensation was that the baby did well, at least in the short-term.

When Dr. Buwembo shared his experience with me six years ago, I was as concerned as he was, but I felt optimistic that Mulago had learned a lesson from it and had identified opportunities for improvement. However, an experience last week by Dr. William Manyilirah, a consultant cardiothoracic surgeon at the Uganda Heart Institute, suggests that, if anything, the situation at Mulago needs radical intervention.

Dr. Manyilirah, a Makerere Medical School graduate who trained as a general surgeon at Mulago and as a cardiothoracic surgeon at the University of the Free State, South Africa, returned home in 2015 to serve Uganda and his alma mater. He wrote an anguished letter last week that invites urgent and close attention by all who care about our once famous hospital. A full copy of his letter, which he posted to a WhatsApp group on Friday, October 26, is available on my website www.mulerasfireplace.com.

The letter describes the last-minute cancellation of planned operations on two patients with very serious chest diseases. The reasons for the cancellation? First, there was no oxygen. When Dr. Manyilirah borrowed an oxygen cylinder from the thoracic surgery ward, he was told that there was no anaesthetist. The senior anaesthetist on duty was reportedly “indisposed” and there was no back-up plan because all the senior house
officers (SHO) were busy attending a research conference. The other anaesthetists were attending to patients in other theatres. It is enough to make one give up.

So why does Dr. Manyilirah continue to offer his skills to Mulago Hospital? “I go to operate at Mulago to share my thoracic surgery skills and knowledge with the SHOs and other surgeons,” he wrote. “I do so to help operate on needy Ugandans with more complex thoracic disease who would otherwise not afford the cost of the same surgery in private hospitals, and to prevent attrition of my hard-earned thoracic surgery skills and knowledge.” He adds: “Other than the above reasons, I have no obligation to work on the Mulago Thoracic Surgery Ward!”

Dr. Manyilirah says “the setup of the Mulago theatre calls for a high degree of sacrifice by right-thinking surgeons and other staff.”

To him, the situation goes against most standard operating protocols and common sense. He sometimes feels that “it takes some degree of insanity to accept to perform specialised surgeries in that operating theatre.”

“On some days, if it is not lack of essential supplies, a surgeon has got to literally beg and cajole the anaesthetist or theatre staff to have a case operated on at Mulago”, he continues. “Sometimes it appears as though the surgeon owns or has a special interest in the patient!”

Dr. Manyilirah observes that nurses and doctors at Mulago Hospital often turn a blind eye to problems in their units because they fear admonition by the hospital administration and even loss of employment.

“This is very disturbing and is a source of despondency among the staff - a recipe for poor service delivery,” he writes. After offering excellent suggestions for remedying the situation, Dr. Manyilirah urges his colleagues to boldly voice their concerns about the poor working environment. “We should not directly or indirectly perpetuate it,” he implores them. He advises the hospital administration to find a way of encouraging the staff to come forward and discuss “the issues openly without fear of being unfairly reprimanded.”

Reacting to Dr. Manyilirah’s letter, a senior consultant surgeon who knows him, said: “I was in charge of theatres at Mulago for over five years. What Dr. Manyilirah, my former student, is talking about is just the tip of the iceberg. Unfortunately, whenever and however one complains makes no difference. One creates more enemies. You just simply keep quiet or give up just as I did.”

Dr. Manyilirah’s choice to go public suggests deep frustration with the absence or failure of internal mechanisms for resolving these problems.

His letter is a patriotic act by one who could have chosen to stay in South Africa or sought opportunities in many other countries. Instead of the Mulago Hospital
administration going on the defensive or taking punitive measures against him, they should engage with him and other stakeholders to find a sustainable solution that provides the best care to patients. Beyond celebrating the newly renovated hospital building, the executive and legislative branches of the Uganda government have an urgent duty to act on Dr. Manyilirah’s concerns. The place to start is a thorough and independent external review of Mulago Hospital, with a view to making necessary radical changes.

In Summary

- Kwale County Commissioner Karuku Ngumo said the girl started having labour pains earlier in the day so she was taken to Kwale Hospital.
- A source at the hospital said she was stable and that she wrote the mathematics test from her hospital bed.
- A candidate at Voroni Primary School in Kwale County gave birth to a boy after the national examinations began on Tuesday.

Kwale County Commissioner Karuku Ngumo said the girl started having labour pains earlier in the day so she was taken to Kwale Hospital.

NO PROBLEMS

A source at the hospital said she was stable and that she wrote the mathematics test from her hospital bed.

"We are happy that the girl delivered without any complications," the source said.

This was the first such case to be reported in the county this year.

The examinations kicked off smoothly, with a total of 8,086 candidates across Kwale.

Mr. Karuku said security was beefed up in all examination centres so they were not anticipating any problems.

“We have tightened security in all our institutions to ensure the examinations run smoothly on the three days," he said.
MONITORING

Education officials, including Cabinet Secretary Amina Mohamed, Principal Secretary Belio Kipsang, Teachers Service Commission chief executive Nancy Macharia and Kenya National Examination Council board chairman George Magoha were at various stations as early as 6am to supervise the opening of exam containers.

Security has been tightened across the country to prevent interruptions.

In Kajiado County, a watchman was arrested for trying to sneak fake papers into an examination centre on Monday night.

In Kakamega County, a man was apprehended for allegedly posing as a candidate during music practicals at Mukuyu Girls' Secondary School.

Meanwhile, the CS said all the candidates, numbering more than a million, will get chances to join secondary schools.

FEATURED: FAGACE, Coqebanque ink deal to finance pharmaceutical plant - Rwanda

By The NewTimes
October 31, 2018

African Guarantee and Economic Cooperation Fund (FAGACE) has signed a deal with Cogebanque to fund the construction of Rwanda’s largest pharmaceutical plant.

The plant, which is being constructed by Apex Biotech, is worth $20 million.

Under the arrangement, Cogebanque will fund the project at unspecified amount while FAGACE will provide a guarantee cover of up to 50 per cent of the total loan.

FAGACE, an international institution specialising in the promotion of public and private investments, signed the memorandum of understanding with Cogebanque yesterday in Kigali.

Minafou Fanta Coulibaly Kone, the Chief Executive Officer (CEO) of FAGACE said that the Fund will continue to work with Cogebanque in financing the growth of Rwanda's small and medium enterprises.

“The guarantee agreement signed today is the first of its kind that FAGACE signs with Cogebanque and marks the beginning of a
lasting cooperation in setting up a line of guarantee for SMEs” she said.

“The most ardent wish is that APEX BIOTECH is a success story and that the Cooperation between FAGACE and Cogebanque strengthens and leads to the signing of several guarantee agreements in favour of several projects” she added.

Cherno Gaye, the Managing Director at Cogebanque stressed the need for more funding for the SME sector, saying that cooperating with FAGACE will enhance the Ban’s SME programme.

“One of the key challenges to companies, particularly SMEs, which are the engine of growth, is access to finance due to lack of a good collateral,” he said.

He added that the agreement will go a long way in solving this issue.

“We are very excited about the myriad possibilities this facility presents” Cherno added.

Apex Biotech said the agreement is a timely boost to its pharmaceutical project.

“FAGACE and Cogebanque have marked the commencement of a paramount partnership for our manufacturing factory in the country” said Dr. A A Faruque the Managing Director at Apex Biotech.

According to Faruque, the plant will begin production in mid-2019, producing some basic medicines needed in the country.

“Our production will focus on medicines for malaria, HIV/AIDS, TB, Hepatitis, heart diseases, diabetes, malnutrition and women and children’s health conditions,” he said.

The first phase of construction will cost $6 million, Faruque.

FAGACE operates in 14 countries including Benin, Burkina Faso, Cameroon, Central African Republic, Congo, Côte d’Ivoire, Guinea Bissau, Mali, Mauritania, Niger, Rwanda, Senegal, Chad and Togo.

The Fund started its operations in Rwanda in June 2015.

It is keen to work with local banks.
Government names best, worst hospitals - Uganda

OCTOBER 31, 2018
By Daily Monitor

The Ministry of Health has named districts and hospitals with the best health service delivery in the Financial Year 2017/2018. The Annual Health Sector Performance Report for 2017/2018 listed best 10 districts in health service delivery as Adjumani, Moyo, Bushenyi, Gulu, Kabarole, Oyam, Kabale, Kamwenge, Sheema and Jinja. The report was released yesterday at the Office of the President in Kampala.

The District League Table (DLT) used to rate the performances is based on input, output and outcome indicators, including staffing levels, tuberculosis detection rate, deliveries in health facilities, and pit-latrine coverage. The report also cited lowest health service delivery levels in Buliisa, Nakapiripirit, Namisindwa, Amudat, Abim, Budaka, Kaberamaido, Mayuge, Amolatar and Luuka. The district health service delivery rating from best to worst ranged between 86 and 56 per cent scores.

The report was released during the 23rd Health Sector Joint Review Mission and Mid-term Review of the Health Sector Development Plan. The theme centred on embracing effective performance management and accountability to move towards universal health coverage.

“The DLT is not meant to embarrass LG (Local Government) leaders of poorly performing districts, but rather make them question why their district is performing poorly, and consider ways in which that performance can improve,” the report states.

In Summary

- The theme centred on embracing effective performance management and accountability to move towards universal health coverage.
- The Health minister, Dr. Jane Ruth Aceng, while commenting on the report, commended improvements scored in several indicators, including maternal health, immunisation coverage, and HIV patients on treatment.

Kampala. The Ministry of Health has named districts and hospitals with the best health service delivery in the Financial Year 2017/2018.
The report also stated that the ranking was intended to help devise corrective measures which may include increasing resources to the local government or offering more frequent and regular support supervision. On a positive note, the report noted an improvement in overall district performance score from 66.2 per cent in the 2016/2017 financial year to 69.2 per cent in 2016/17 financial year. It noted remarkable reduction in maternal deaths in the years under review.

But the district health officers (DHOs) from some of the worst performing local governments blamed their woes on inadequate human resource and poor community awareness on accessing health services.

**Challenges**

Dr. Nelson Naisye, the Buliisa DHO, cited several hurdles, including the remote location of the district. He also said Buliisa is new having been carved out of Masindi District only in 2006. “The biggest problem is the lack of equipment to run theatres in our Health Centre IV and General Hospital. And being a remote district, attracting and retaining personnel is also a challenge, which has compromised the quality of health services in the district,” Dr. Naisye said.

For Budaka District, also named among the lowest performers, its health officer, Mr. Erisa Mulwani, blamed the perennial challenge of understaffing that stands at only 66 per cent. “Communities also shun immunisation and deliveries at health facilities,” Dr. Mulwani said.

Dr. Anthony Okengo Okuda, the Abim DHO, said: “You come [to Abim] and see for yourself. I cannot comment.”

On the other hand, Dr. George Bhoka Didi, the DHO of Adjumani, which was ranked best, attributed their success to the “effective stewardship, team work and several partners attracted by the desire to offer humanitarian assistance.”

The Health minister, Dr. Jane Ruth Aceng, while commenting on the report, commended improvements scored in several indicators, including maternal health, immunisation coverage, and HIV patients on treatment. The best performing general hospitals were listed as Iganga (best), Mityana (second) and Kagando, which is private and not for profit hospital (third).

Mbale was also named best among the regional referral hospitals followed by Masaka and Mbarara. The best performing health centres were named as Kisenyi, which is run by Kampala Capital City Authority, Mukono Town Council Health Centre IV and Luweero Health Centre IV.

**Government questions high rate of C-section births**

NOVEMBER 1, 2018

By Daily Monitor
Operating. Doctors carry out surgery on a patient recently. Hospitals have registered an increasing number of mothers seeking to under-go caesarean sections rather than normal delivery.

Kampala. The Health ministry has raised questions on whether the marked increase in delivery of babies by caesarean at private-for-profit and private-not-for-profit hospitals is commercially-motivated or out of medical necessity. “The number of caesarian sections are very high and the question is: could it be for commercial purposes because you pay more than the normal deliveries?

All these questions need to be answered,” Dr. Henry Mwebesa, the acting director general Health Services, said while presenting the Annual Health Sector Performance report on Tuesday. Private hospitals in the country on average charge at least Shs500,000 for normal deliveries compared to C-section delivery that costs triple or four-fold higher. The Health ministry report released on Tuesday indicates that the average rate of C-sections in the general hospitals have within a year increased by three percentage points to 28 per cent from the 2016/17. Nakasero Hospital in Kampala recorded the highest rise. Regional referral hospitals within the same period registered a 3.4 percentage point rise in deliveries by C-section. St Francis Nsambya and Rubaga hospitals, both church-run private-not-for-profit facilities in the capital, categorised by Health ministry as regional referral hospitals, top in delivery of babies through C-section, according to the report. Gulu Regional Referral Hospital on the other hand had the lowest C-section deliveries at 12.3 per cent. Mukono, St Paul, Mpigi, Rwekubo and Kyegegwa health centre IVs had the highest deliveries by C-section. Dr. Charles Kiggundu, a consultant gynaecologist at Mulago National Referral Hospital, said the higher figures likely indicate that more expectant women with complications now give birth at hospitals. “Women who go to hospitals are those who identify themselves as requiring C-section. The figures do not reflect those women in communities who do not produce in hospitals,” he said by telephone. It is unclear if Ugandan experts have done a research on the impact on women of deliveries by C-section, which some families --- especially those with means --- prefer for its perceived safety.

CANCER WARRIOR: A bundle of joy in the middle of gloom

NOVEMBER 1, 2018

By Daily Nation
In early 2007, I had noticed a lump on my right breast but I kept ignoring it because it was painless. I didn’t think it was anything serious. I was only 22.

However, a few months to completing my college studies, I started experiencing some symptoms that pushed me to consult a doctor.

The lump had grown and would shift whenever I tried to trace it. My breast also became sensitive to touch and the veins on them became more visible. I would also feel spasms of pain originating from my underarm, all the way to the right breast.

**DIAGNOSIS**

Immediately after writing my final paper in December 2007, I went to see a clinician, who said that it was normal for young women to sometimes get lumps, but he still sent me for a mammogram to rule out any disease or medical condition.

My first consultation was in a clinic, but I decided to take the results to a bigger hospital. The doctor there ordered a series of more tests, including a biopsy.

When I went back for my results, the doctor insisted that I should be accompanied by an adult. I wondered why he insisted on that yet I had been going for all tests and appointments alone. And I didn’t think I was suffering from any serious disease.

Due to his insistence, I came back with my mother a few days later. I clearly remember...
the look on her face when the doctor said that the tests confirmed I had cancer. My mother broke down, while I was just there smiling.

I could not comprehend what he had just said because I had never thought of the possibility of cancer, even while I was undergoing the tests.

So I sat there smiling at my doctor, oblivious of the weight of the diagnosis. The doctor took his time to explain the disease as well as the treatment options I should consider.

He said my cancer was hormone receptive, meaning a lot of oestrogen in my body triggered the disease. I had two options, either undergo a mastectomy and hormonal treatment for five years, or undergo a lumpectomy followed by chemotherapy, radiotherapy and the hormonal treatment.

My doctor believed I was in denial and he immediately sent me to a counsellor.

We set an appointment for a week later so he could consult other cancer specialists on the best treatment option. This one week was also meant to help me come to terms with the diagnosis, which it did; as well as give me the opportunity to seek further counselling.

**LOSING MY BREAST**

At the next appointment, my doctor advised on the mastectomy and hormonal treatment because the cancer was still in its early stages.

This option, I was told, was also valuable in preventing reoccurrence of the cancer.

We went back home to think about the advice. The doctor had asked us to take the shortest time possible to decide on the method of treatment to stem the spread of the cancer.

It was a difficult time for my family. We needed to settle on a treatment option.

We consulted two of my relatives who are doctors, and they advised us to seek a second opinion, which we did. The results were the same, and the doctors we consulted also advised on the mastectomy.

It took a while for me to come to terms with the idea of losing a breast. But we had no other option. It was either that, or I lose my life to cancer.

The surgery was scheduled and done in May 2008, the year I turned 23. After the surgery, I was put on hormonal therapy, which involved taking tablets every day for five years. The medicine came with side effects, including hot flashes, mood swings and general weakness. It was however all worth it as I was given a clean bill of health afterward. I have been cancer free since!

It was a tough time for me having to accept the fact that I had cancer and rearranging my life to fit into the society after my losing my breast.
It took a lot of energy, prayer, encouragement and counselling, but I pulled through it.

LIGHT AT THE END OF THE TUNNEL

After my surgery and hormonal treatment, I had a positive experience. I got pregnant and had baby girl, who is now a healthy, bubbly and intelligent five-year-old. My daughter is my miracle.

When I was receiving treatment, my family cared for me and gave me financial support. My mother was a super mum during my treatment, which took a toll on her emotionally and financially. But her support never wavered and because of that I never missed an appointment, or taking drugs, or felt unsupported or alone. My extended family also played a big role in supporting us both financially and emotionally.

Sometimes fear would creep in over cancer, especially while I was breastfeeding. I breastfed my baby on one breast until she was two years old. On many occasions, my breast would get lumpy and painful. There was a time the lumps really scared me that I went to consult my doctor. He diagnosed it as mastitis—an inflammation of the breast tissue due to infection—and said that it was normal.

Surviving cancer has made me more aware of my body and alert to changes. I have been going for annual routine check-ups since I completed the treatment. My doctor is always on my speed dial in case that I experience anything.

Routine screenings are very important for everyone. Women and young girls should also learn to self-examine themselves so they can note any changes early.”

Fact Box- According to the Mayo Clinic

Mastitis – an inflammation of breast tissue that sometimes involves an infection. It results in breast pain, swelling, warmth, redness, fever and chills. Most commonly affects women who are breastfeeding.

Oestrogen – hormones produced by the body that help develop and maintain female organs.

Lumpectomy – surgery to remove cancer or other abnormal tissue from the breast.

Mastectomy – surgery to remove all breast tissue as a way to treat or prevent breast cancer.

Uganda confirms case of Crimean-Congo fever near DRC border

NOVEMBER 1, 2018
By The East Africa
Health authorities in the country have confirmed a case of Crimean-Congo haemorrhagic fever in the area.

In Summary

- Samples taken from a patient under isolation at the Fort Portal Regional Referral Hospital in Kabarole District tested positive for the fever.

Uganda confirmed Tuesday a case of Crimean-Congo haemorrhagic fever (CCHF) near its western border with the Democratic Republic of Congo.

Health officials said samples taken from a patient at the Fort Portal Regional Referral Hospital in Kabarole District — about 10 km from the DRC border — tested positive for the fever.

The patient, a woman, was placed in isolation at the facility.

Dr. Richard Mugahi, the Kabarole District director of health services, said a search for all individuals suspected to have been in contact with the patient was ongoing.

Teams from the ministry of health, agriculture and livestock have been sent to the area to contain the outbreak.

The disease is caused by a tick-borne virus (Nairovirus) of the Bunyaviridae family, according to World Health Organisation (WHO). The virus is transmitted to people from ticks and livestock.

Human-to-human transmission occurs from close contact with blood, secretions, organs or other bodily fluids of infected persons.

The virus can cause severe viral haemorrhagic fever outbreaks.

It has a no vaccine or cure and has an average fatality rate is around 30 percent, varying from 10 percent to 40 percent, according to the WHO.

The UN health agency recommends similar guidelines for infection control as those of other haemorrhagic fevers - Ebola and Marburg.

CCHF is endemic in Africa, the Balkans, the Middle East and Asian countries.

It was discovered in Crimea in 1944 and recognised in 1969 as having caused illness in the Congo in 1956.
WFP calls for more effort to end hunger, malnutrition

NOVEMBER 1, 2018
By Daily Monitor

A child is fed on porridge at Rhino Settlement Camp in Arua District in January last year. World Food Programme says proper meals and good feeding practices are vital for a child’s growth.

The World Food Programme (WFP) Country Director, Mr. El-Khidir Daloum, has called on the communities to end child hunger and prevent all forms of malnutrition in order to address stunting in the country. Speaking at the West Nile and Acholi leaders conference on Tuesday, at Muni University Hall in Arua District, Mr. Daloum said preventive measures must be emphasised early enough to avoid spending money on treating diseases among children. “The top challenges could be the kind of food and feeding practices. We need holistic strategies to prevent children from becoming malnourished,” he said.

WFP is scaling up the fight against hunger and stunting of children through a five-year plan to improve dietary intake, increase food production, link small-holder farmers to markets, feed children in schools and provide relief assistance to refugees. Currently stunting among children in West Nile stands at 23 per cent. “While we continue to meet the daily food needs of refugees, it is urgent to also focus on the challenges of the Ugandan communities that continue to receive them and live side by side with them peacefully,” Mr. Daloum said.

He added: “The West Nile region faces high stunting rates as well as small-holder farmer’s livelihood challenges. We need to strengthen local governments to scale up the fight against all these.” The Minister for Local Government, Mr. Tom Butime, said hosting refugees has created immense pressure on the available resources such as food. “But there is need to create positive change for the people to fight hunger and stunting because we should also focus on the Sustainable Development Goals 2 and 17 that call for zero hunger by 2030 and building partnerships for the goals,” he said.

Ms. Sarah Munduru from Adumi Sub-county said: “We give our children what we eat. If you are financially handicapped to buy food with good proteins as recommended by the doctors, then there is no option. Even then
breastfeeding is now a problem to me because I also fail to eat well. It is unfortunate that poor feeding affects the children more.”

According to the Uganda Demographic and Health Survey 2016 report by the Uganda National Bureau of Statistics, the number of children suffering stunting has reduced but overall malnutrition still remains high. The prevalence of stunting among children under the age of five has declined from 45 per cent in 2000 to 29 per cent in 2016.

ABOUT STUNTING

Stunting happens when children experience poor nutrition, suffer disease and lack psychosocial stimulation. It often occurs before a child reaches the age of two. It can have long-term effects including poor performance in school, lost productivity and an increased risk of nutrition-related non-communicable diseases.

Compiled by:

EAST AFRICAN HEALTH PLATFORM
P.O Box 357, ARUSHA - TANZANIA
Plot # 137/1, Kijenge GG - Off Nelson Mandela Road
+255 739 357 000 - eahp@eahponline.net - www.eahponline.net