SALEM-Uganda at 40 years – Mission unaccomplished!?

Reflections by a long serving employee of SALEM-Uganda

Introduction

From a visionary dream SALEM-Kolonyi Children's home took root from the solid empathy and big heart of the late Muller Gottfried and his compassionate German friends of 1981. Sadly, all but one are physically gone, but their monumental legacy of compassion, kindness, generosity and foresightedness lives on, transcending ethnic, political, gender, racial, religious and geographical divides to advocate and foster good health and meaningful livelihood for many poor people of Uganda in particular Mbale District and now Mbale city. SALEM has tirelessly endeavored to provide hope for the indigent, especially the vulnerable orphans and otherwise helpless children; providing skills for the disabled, professional training for nurses and providing employment for various cadres of workers. Professional doctors, nurses, midwives, clinical officers, technicians like plumbers, artisans, carpenters, tailors to support staff who have all been able to educate their children. We are all very grateful and we thank the Almighty God for the invaluable gift of SALEM.

My engagement

I was recruited purely on merit through a "head hunt" process by staff members I had worked with elsewhere. Although I was reluctant at the beginning, the privilege of working with SALEM-Uganda for the last 33 years has been an enriching experience in terms of understanding the health system and its interrelationship with socioeconomic transformation. I am a Ugandan Doctor who qualified 10 years before the establishment of SALEM-Uganda. My career path was zig zag with stints as a general medical officer, medical superintendent, District medical officer, Senior house officer eventually qualifying as a General surgeon at the time SALEM-Uganda was started. When I joined SALEM as a visiting surgeon in 1988, I got the first experience of working in a rural setting, isolated from the hospital, working close to where the clients lived. I started appreciating the gaps in our health system, notably the inverse care, also called the 20/80 service availability discrepancy (only 20% of clinicians work in the rural communities where 80% of the population lives a glaring inequity in social services. The burden of diseases like measles, diarrheal diseases whooping cough, all related to poor personal and community hygiene, poor water supply and lack of basic sanitation and simple knowledge about the spread of such diseases in the communities were rampant. The high disease burden diverted the

women from agricultural production resulting in nutritional deficiency especially among the under-fives.

By coincidence, in 1989, a year after joining SALEM an opportunity to train general medical officers in Uganda for rural practice became a reality, funded by CIDA Canada through a grant to Makerere University Medical school. I was appointed on the faculty to train Community Practitioner later changed to family Physicians, likely to run rural health units where the majority of people live and often present with undifferentiated morbidity, with minimal diagnostic technological support, who therefore, needed a critical body of knowledge and skills including simple surgery. As head of this program till 2002 SALEM Health center was occasionally used as a practicum site and was a source of data for generating research themes for the students. By that time, I had personally operated on more than 2000 people in various hospitals but this only appeared on my curriculum vitae making no tangible impact or legacy.

I was therefore exceedingly happy to associate with SALEM-Uganda whose memorandum of understanding and articles of association mandated it;

1. To improve the lives of the less fortunate by giving them access to basic services available to the rest of the society they live in.
2. To provide education, health care, nutrition and basic services to needy people who meet the criteria set by the Organisation.
3. To promote sustainable economic and environmentally friendly programmes for rural communities such as agroforestry, water and sanitation among others and most importantly
4. To network with Government, welfare agencies, locally an internationally.

Working with SALEM one witnesses the sustained, systematic implementation of these aspirations to achieve the targeted gradual socioeconomic transformation to wit.

ACHIEVEMENTS

a) IN THE COMMUNITY

- **Water related diseases**

In earlier days, the first decade, I witnessed and actively participated in the dramatic eradication of measles, whooping cough, acute paralysis and diarrheal diseases in our catchment area through simple interventions and cooperating with the District Health team. Wells were protected, springs protected, bore holes sank as well as education using community Health Workers, peer education.

A demonstration garden and nutrition follow ups in the communities improved childhood nutrition

- **Tree planting**

To counter deforestation free seedlings were raised and distributed free to households. I was one of the beneficiaries and I am proud of my wood lot.

- **HIV/AIDS control**

In the first- and second-decades HIV/AIDS took center stage. SALEM in partnership with USAID and the District Health Team successfully sensitized communities about the spread and

prevention of HIV/AIDS. SALEM participated in the programmes for mitigation of the effects of HIV/AIDS. Vocational training was provided for the orphans, widows and startup funds availed for income generating activities to support the families.

b) INFRASTRUCTURE DEVELOPMENT

There has been gradual but steady infrastructure development when demand coincides with timely financial support from development partners. From an Aid post under a backcloth tree a 69-bed hospital has evolved over the last 30 years with an operating theatre, a maternity unit, a laboratory 2 stand-alone wards and a general ward and an outpatient department. A nurses training school has been under construction house by house since 2009. All major constructions are the gift of our development partners and value their support. There is no better tribute to them than always putting their funds to the intended use.

Fortunately, accountability and transparency have been our core values in the management of funds availed for projects and an asset in our networking and resource mobilization. All staff always get to know who has donated and for what purpose and all keenly monitor the progress of the implementation.

c) CAPACITY BUILDING

With limited resources staffing is a tricky issue given the contemporary competitiveness. Many cadres are trained on the job and upgrade when they eventually undertake relevant courses to attain the necessary standards. Professional development sessions ensure practice standards are maintained. Many have benefitted from donor funded trainings, nurses, laboratory technologists. By and large the organization policy is to train our own with commitment so vital for staff retention.

CHALLENGES

Despite these many successes, many challenges exist. These include resurgence of old problems, anticipated problems like depreciation, changing consumer preferences and trends, shifts in service delivery and changing Government Policy which impact on SALEM work, calling for modifications in the approaches adopted to sustain our achievements and secure the future of SALEM-Uganda.

i) Resurgence or persistent problems
   - Kwashiorkor

I found community involvement the most interesting in SALEM. I first heard the word kwashiorkor from a guest speaker when I was in senior five. This was my turning point. I had earlier looked forward to becoming a prestigious lawyer, but seeing the piteous photographs of the sad, oedematous children recover on appropriate feeding won me over to do medicine. In my first decade of practice, there were hardly any cases in the hospitals I worked in, when I joined Kolonyi in the wake of political upheavals and the onslaught of HIV/AIDS they filled the nutrition ward. This ward had closed until the 2020 Covid-19 restrictions which meant loss of jobs an income, extra months at home as the schools were closed. All this occurring in a society where arable land per capita has dwindled and soil fertility washed or whispered away. The little harvest also provides fees and other deliverables as well as the out-of-pocket expenses for

illness episodes, sadly sometimes even the land must be sold in emergencies. The mothers are victims of teenage pregnancies, the fathers are unskilled school dropouts hence the resurgence of malnutrition, rekindling the old vicious cycle of ignorance, poverty and disease. The latest National labour force survey 2016/17 quoted by the Daily monitor of 10th March 2021 indicated that the majority of Ugandan youths aged 18 to 30 years are either unemployed or erratically employed in the informal sector. These statics must have changed with COVID-19. Less than 15% have formal jobs. 7 in 10 Ugandans are engaged in agriculture for subsistence with unpredictable changing rainfall patterns.

Women comprise 82% of the agricultural workforce in Uganda. Sadly, today it is the elderly women left to till the land. This weak workforce impacts negatively on the food production, the Covid-19 stigma has affected hired labour as it has increased sexual and gender base violence, anxiety, stress and various hardships to families which result into broken marriages and food gaps.

Poor parenting under such social environment and the all-pervading poverty has and continues accounting for early teenage pregnancies and child mothers, the recipe for malnourished children.

- Malaria

Despite sustained Government interventions with the malaria consortium for a decade now malaria remains the leading reason for outpatient attendance up to 4% of attendance accounts for admissions in the low-level rural health units Kolonyi inclusive. Indoor spraying and treated mosquito nets use clearly complementary interventions like housing styles and behavior change, perhaps mass treatment may be an option yet unconsidered because of the prohibitive cost.

ii) Anticipated

- Population explosion as a result of the successful under-five survival strategies in the past decades and improved health care with high school dropout rates up to 20% especially for girls means unskilled and unemployable youths growing into helpless community members.
- Depreciation of buildings has taken toll on the operating theatre and maternity units needing complete overhaul. The ambulance has served well for years but is now limping and soon it will be a liability.

iii) Changing consumer expectations and values

Among the challenges of the changing world longer lives (aging) is one of the most significant ones because of the gradual, almost imperceptible population explosion is not anticipated, only becoming a reality at the next census, therefore there is slow and tarda reaction to its effects growing overcrowded slums called urbanization, mushrooming trading centers / towns in once organized agro villages put social cohesion of traditional villages under stress. The health system being a key constituent of the contemporary society cannot perform to the expectations of all globally engulfed in galloping pharmaceutical and technological development, health care delivery is facing challenges at different levels. Internationally the responses have fallen victim to fragmentation, concentration in selected programmes or diseases. Nationally the health

system is drifting towards uncontrolled, unregulated commercialization resulting into impoverishing care, inequity and inverse care; denying especially the rural poor financial access to services they need, and failure by the modest institutions to provide services in ways that correspond to the expectations of the affluent. How can we achieve the cherished universal coverage Covid-19 effects on Health?

While the government has done tremendous and commendable job to contain the pandemic predictably some health services are inaccessible because of stigma. Nationally antenatal care attendance dropped by 7% while facility supervised deliveries have dropped by 10%. This meant a reduced footdrop to the health facility since last year 2020, making too low revenue collections to afford remuneration, drugs and supplies replenishment as well as providing personal personnel precaution equipment and other provisions and other SOPs requirements; let alone mobilization and sensitization in the communities so vital in addition to the anticipated vaccination for control of the pandemic.

This is in addition to the effects alured to earlier- unemployment plight, domestic fragility to rising sexual and gender-based violence, teenage pregnancies and early unstable marriages.

PROJECTIONS FOR THE FUTURE

Government is addressing the effects of Covid-19 on social and economic well-being of the population and has a Covid -19 response plan to address gender-based violence and violence against children. SALEM will participate as opportunity will provide. There are revised guidelines for prevention and management of teenage pregnancies in the school settings.

SALEM can complement Government efforts to scale up initiatives for skilling and income generation for women, youths and other vulnerable groups. Operationalization of the St Martin project, the briquette making project, revamping our vocational trainings, tailoring, carpentry, catering, metal works.

Enhance use of ICT for better data collection and analysis for planning is planning.

The SALEM Green belt and integration of gender in the climate change mitigation. With appropriate partnerships thus should flourish to ultimately counter the growing water scarcity.

Family planning now more than ever is a slogan of determination to bridle the population growth.

Finally, our approaches may need to be changed to fit the changing world.

A comprehensive response to people’s expectations in the health care delivery stretches beyond the original Alma Ate tenets. The needs are wider than a few diseases, promoting of healthier lifestyles and mitigation of the health effects of social and environmental hazards in addition to improvement of hygiene, water, sanitation. To tackle the neglected tropical diseases, the increasing non-communicable disease burden in our communities now under the gambit of universal coverage and social health protection.

Yes, PHC is still very relevant but today PHC is not about managing growing scarcity and downsizing, it requires considerable investments, and guiding of the growth of revenue for health towards universal coverage. From simple technology hitherto advocated, from volunteers and mainly untrained CHWS, VHTs, Peer educators to teams of health workers facilitating access to and appropriate use of technology and medicines, institutional participation of civil

society in policy dialogue and accountability mechanisms. An integrated Health Information management system requires computerization of digital migration as commonly referred to. Such modernity requires appropriate capacity building in terms of human resource training and appropriate working environment. Kolonyi Hospital SALEM has therefore a master plan for infrastructural development in the 5-year 2020-2024 strategic development plan. This plan is begging for funding and an be availed to prospective development partners.

Community Health Financing mechanisms to reduce on catastrophic out of pocket health expenditure is underway to empower community members to comfortably access such new service that might become a reality.

I would like to thank the Project Director, the Board of Directors, the school Governing Council, the hospital management board and all fellow staff of SALEMUganda for the unflinching dedication all these years. My gratitude also goes to all development partners who have helped shape SALEMUganda of today and many years to come.

Dr. Tuunde Stephen
Retired Senior Consultant Surgeon
Visiting Surgeon Salem Uganda since 1988
Medical Coordinator Salem Uganda since 1996 to date

Handing out certificates to nurses

With Denis Medeyi, Director (right)