THE REPUBLIC OF UGANDA

IN THE HIGH COURT OF UGANDA AT KAMPALA

[CIVIL DIVISION]

HIGH COURT CIVIL SUIT NO. 212 OF 2013

1. CENTER FOR HEALTH, HUMAN RIGHTS AND DEVELOPMENT (CEHURD)
2. MUBANGIZI MICHEAL
3. MUSIMENTA JENNIFER.....PLAINTIFFS

VS.

1. EXECUTIVE DIRECTOR OF MULAGO NATIONAL REFERRAL HOSPITAL
2. ATTORNEY GENERAL.....DEFENDANTS

REPORT ON THE IMPLEMENTATION OF THE JUDGEMENT

1.0 INTRODUCTION

This report is made in light of the order given by Court on January 24th 2017 requiring the 1st Plaintiff, CEHURD to make reports on the implementation of the judgment delivered by Honorable Lady Justice Lydia Mugambe in favor of the Plaintiffs and entails an update of the steps taken by all the parties in the suit in the implementation of the Court judgment from the 4th of May, 2017 to date.

This case arose on the 14th of March, 2012 when the 3rd Plaintiff (wife to the 2nd Plaintiff) delivered twins at Mulago National Referral Hospital's general labor ward. The 2nd and 3rd Plaintiffs were discharged from hospital with only one child and without the body of their allegedly dead child. A DNA examination of the said dead body confirmed that the 2nd and 3rd Plaintiffs had no biological connection to the body that had been given to them at the hospital. The Plaintiffs then instituted the suit to hold the defendants accountable for the violation of the Right to Health and for the unlawful disappearance of the 2nd and 3rd Plaintiff's baby on the 18th of July, 2013 at the High Court of Uganda, at Kampala, Civil Division.

1.0 OBJECTIVE OF THE REPORT

This report highlights the process of implementation of the judgment in Civil Suit No. 212 of 2013 in light of the orders as directed by the Court.

a. **ORDERS AND DECLARATIONS GRANTED BY COURT**

In determining the matter, Honorable Lady Justice Lydia Mugambe made the following orders in the judgment which this report will analyze.

1. The Police must conclusively investigate the disappearance of the baby of PW1 and PW2 in issue and file a report on the same in Court within 6 months from the date of this judgment at the latest.
2. Ms. Mandida Mariam the midwife who handled the baby at birth must be held to account for the movement of the baby from her care.
3. Mulago hospital shall take steps to ensure and/or enhance the respect, movement and safety of babies, dead or alive, in its facilities.
4. For two years from the date of this judgment the 1st Defendant shall make written reports, every four months, regarding the steps or measures taken in fulfilling (3) above and serve the same on the 1st Plaintiff.
5. The 1st Plaintiff shall have free access to Mulago hospital and continuously oversee the implementation of the measures in (3) above and make counter reports on their effectiveness or otherwise within two months from the date of receipt of the 1st Defendants reports.
6. The 1st Plaintiff shall ensure that the 2nd and 3rd Plaintiffs access psycho-socio care and counseling services as part of their healing. Mulago hospital shall pay for any attendant costs in this regard.
7. Where necessary this Court reserves the right to make further orders regarding the implementation (3) above.
8. The 2nd and 3rd Plaintiffs are awarded Ug. Shs. 85,000,000/= (Uganda Shillings Eighty Five Million only) as general damages for the psychological torture, violation of their rights to health and access to information resulting from the disappearance of their baby at Mulago hospital.

4.0 SPECIFIC STEPS UNDERTAKEN ON THE IMPLEMENTATION OF THE ORDERS IN THE JUDGMENT

4.1 Conclusive Investigation of the disappearance of the baby by the Police

The first order required the Police to conclusively investigate the disappearance of the baby of the 2nd and 3rd Plaintiffs and file a report on the same in Court within 6 months from the date of Judgment at the latest.

Several follow-ups were made to ensure that the report was made and delivered. The 1st Plaintiff was reliably informed by the assigned officer stationed at Wandegeya Police Station that the report was

finalized and duly submitted to the Police Headquarters in Naguru. However, the 1st Plaintiff did not receive a copy of the completed report.

4.2 Accountability for babies' movement

The second order required Ms. Mandida Mariam, the midwife who handled the baby at birth to be held to accountable for the movement of the baby from her care.

On 19th February 2018 the 1st Plaintiff, through its Lawyers Dalumba Advocates wrote a letter referenced as DALUMBA/01/06 to the Registrar of the Uganda Nurses and Midwives Council requiring the Council to investigate and undertake disciplinary action against Ms. Mandida Mariam. ***(Letter attached as Annex A)***

On 23rd February 2018, the Nurses and Midwives Council wrote to Ms. Mandida Mariam directing her to respond to the complaint. The Council sat in November 2018 and heard the complaint but the ruling has as of today, not yet been delivered.

4.3 Safety of babies at Mulago National Referral Hospital

The third order was for Mulago Hospital to take steps to ensure and/or enhance the respect, movement and safety of babies dead or alive in its facilities.

On 13th April 2018, the 1st plaintiff wrote to the Executive Director of Mulago Hospital seeking authorization to visit Mulago National referral hospital to follow-up on implementation of the High Court decision. ***(Letter attached as Annex B)***

On the 16th May 2018, the 1st Plaintiff had a meeting with the representatives of Mulago National Referral Hospital to discuss the steps taken by the hospital in the implementation of the judgment. The representatives of the hospital included; Principal Hospital Administrator of Mulago National Referral Hospital, Public Relations Officer Mulago, the Acting Senior Hospital Administrator, the Accounts Officer Mulago and the Senior Hospital Administrator.

The principal hospital administrator of Mulago National Referral Hospital stated that that the Hospital had taken steps to ensure the movement and safety of babies within the hospital premises. The hospital shared the Directorate of Obstetrics and Gynecology Manual effective January 17th 2017 that set out Standard Operating Procedures (SOPs) on how babies are handled in the hospital. The SOPs exhaustively state the procedure on how a pregnant mother is handled at Mulago National Referral Hospital from the time of admission up to the time of discharge. **(A copy of the Guidelines is attached as Annex C)**

On 30th October 2018, the 1st Plaintiff, together with Principal hospital administrator of Mulago hospital conducted a monitoring visit at the New Mulago Specialized Women and Neonatal Hospital to assess the management of newborns. They assessed sections of the Hospital inclusive of the delivery suite, postnatal suite and neonatal intensive care unit and found the following;

4.3.1 Identification of newborns

The hospital adopted a routine where all births are registered in the birth registration book, the newborns are labelled upon birth and by the time of the visit, the hospital officers were using a plaster to identify the newborns but they indicated that they had ordered for labels.

4.3.2 Counselling of mothers whose babies have died

The hospital has established a compassion ward. The mothers who have lost the babies receive counselling services in that ward.

4.3.3 Management of dead babies

Where a new born dies, the midwife shows the mother the body of her deceased baby. Thereafter, the mother confirms the death in writing in the language she understands and the confirmation is witnessed by the attendant and the midwife. The doctors certifies the death and a death certificate is made. The body of the baby is then wrapped and a tag is used to identify the body. The particulars of the tag include; time of death, date of death, name of the mother, sex of the baby, birth weight and address of the mother.

The midwife then has to notify the mortuary attendants about the death. The mortuary attendant signs for the body of the baby and this is witnessed by a midwife. The family of the deceased baby then follows up the body at the mortuary.

4.3.4 Security

Regarding the security at the hospital, they have since installed CCTV cameras in all corners of the hospital, installed baggage scanners at the main entrance of the hospital, there's mandatory registration of every patient or visitor at the entrance, all bags and cars are checked when entering and exiting the hospital, no patient leaves the hospital without a clearance form, there's restricted access to all the units in the hospital and only authorized hospital staff have to sign into the security systems and the security guards are deployed at the entrance of all units.

It's important to note however, that although the Hospital management has taken positive and targeted steps towards the realization of the measures to ensure the accountability for babies' movement in the hospital, these measures have only been implemented in the New Mulago Specialized Women and Neonatal Hospital whose services are accessed at a cost and not at Kawempe National Referral Hospital whose services are free of charge and used by majority of the pregnant mothers in the country.

4.3.5 Monthly reports on implementation of the judgment

The fourth order was for the 1st Defendant to make written reports for two years from the date of this Judgment every four months regarding the steps/measures taken.

On 21st June 2017, the 1st Plaintiff through its Lawyers Dalumba Advocates wrote a letter referenced as DALUMBA/06/30 requesting the Executive Director of Mulago Hospital to file a report on the efforts made in implementing the Court orders in HCCS No. 212 of 2013.

On the 1st of June 2018, the 1st Defendant submitted the manual for the Directorate of Obstetrics and Gynecology (Quality management System ISO 9001) and it includes the steps taken by the 1st Defendant to ensure the safety and movement of babies dead or alive. **(Letter and Manual are attached as Annex D and C respectively).**

4.4 Plaintiffs access to psychosocial support

The sixth order was that the 1st Plaintiff shall ensure that the 2nd and 3rd Plaintiff access psycho-socio care and counselling services as part of their healing and Mulago National Referral Hospital shall pay for any attendant costs in this regard.

During the Meeting held on 16th May 2018, Principal hospital administrator of Mulago National Referral Hospital affirmed that the hospital shall provide psycho-social care and counselling services to the 2nd and 3rd Plaintiffs on a scheduled date. The 2nd and 3rd Plaintiffs received the psychosocial support as prescribed in the order at the New Mulago Specialized Women and Neonatal Hospital.

4.5 Orders as to damages

The 2nd and 3rd Plaintiffs were awarded Ug. Shs. 85,000,000/- (Uganda Shillings Eighty Five Million) as general damages. The parties agreed that the payment would be made in installments as agreed upon in a letter dated 13th August, 2018 from Mulago National Referral Hospital. **(Letter attached as Annex F).**

Following a number of engagements with the Hospital administration and the 1st Plaintiff, over payment of damages, the hospital paid the sums awarded in installments with the first installment amounting to Ug. Shs. 25,000,000/- (Uganda Shillings Twenty Million) paid on 18th March 2019 and the second installment amounting to Ug. Shs. 60,000,000 (Uganda Shillings Sixty Million) paid on 6th March 2020, and the money was duly received by the family of the 2nd and 3rd Plaintiffs.

5.0 COURT'S DISCRETION TO MAKE FURTHER ORDERS ON MEASURES TO ENSURE AND/OR ENHANCE THE RESPECT, MOVEMENT AND SAFETY OF BABIES, DEAD OR ALIVE, IN ITS FACILITIES

The court's last order states that where necessary, this Court reserves the right to make further orders regarding the implementation of the measures to ensure and/or enhance the respect, movement and safety of babies, dead or alive, in its facilities.

It's in light of this order that the 1st Plaintiff notes that there are orders that are not fully implemented and prays that this Court makes further orders that:

1) The 1st and 2nd Defendants put in place measures for safety and management of newborns at Kawempe National Referral Hospital to enhance the respect, movement and safety of babies, dead or alive in the hospital.
2) That the 1st Plaintiff be granted permission to inspect the premises of Kawempe National Referral Hospital to assess the implementation of order (1) above.
3) The 1st Defendant to file all pending reports in Court as directed in order (IV) of the judgment.
4) The Police to file a conclusive report on the disappearance of the baby of the 2nd and 3rd Plaintiff and file the same to the Court and serve a copy to the 1st Plaintiff as well.
5) Grant any other order that Court deems fit.

6. CONCLUSION

Although some orders as directed by Court have been implemented, others have not been fully implemented such as putting in place measures for safety and management of newborns at Kawempe National Referral Hospital, filing of reports by the 1st Defendant in Court and filing of the Police report. Since Court reserved the right to make further orders, the 1st Plaintiff therefore prays that Court makes further orders to facilitate the full implementation of the judgment.

Dated at Wakiso this 23rd day of March 2021.

CENTER FOR HEALTH, HUMAN RIGHTS AND DEVELOPMENT (CEHURD)

(1ST PLAINTIFF)

CENTER FOR HEALTH HUMAN RIGHTS & DEVELOPMENT (CEHURD)
23 MAR 2021
P.O. BOX 16617
WANDEGEYA - K'LA

DRAWN AND FILED BY:

Center for Health, Human Rights and Development,
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Nakwero, along Gayaza- Kalagi Road,
P.O.Box 16617, Wandegeya,
Tel. No. 0414-532283

19th February 2018

DALUMBA/01/06

"A"

The Registrar
Uganda Nurses and Midwives Council
Kampala

Dear Sir,

RE: INVESTIGATION AND DISCIPLINARY ACTION AGAINST MS. MANDIDA MARIAM

Reference is made to the above.

We act for and on behalf of the Center for Health, Human Rights and Development (CEHURD), Mubangizi Micheal and Musimenta Jennifer (hereinafter referred to as "Our Clients") on whose instructions we address you as hereunder;

We note that our clients filed Civil Suit No. 212 of 2013, CEHURD and Ors vs. The Executive Director, Mulago National Referral Hospital and Anor challenging the disappearance of a new-born at Mulago Hospital. The judgment was delivered in favour of our clients.

One of the orders of the High Court calls for holding Ms. Mandida Mariam, the midwife who handled the baby at birth accountable for the movement of the baby. As part of your mandate, the Nurses and Midwives Council is empowered under Section 3(b) of the Nurses and Midwives Act to regulate the conduct of nurses and midwives and exercise disciplinary control.

We are therefore writing to request you to conduct an investigation and undertake disciplinary action against the said midwife as ordered by the Court. Copy of the Judgment and decree are herewith attached.

Yours Sincerely,

Dalumba Advocates
Cc: The Registar, High Court of Uganda, Civil Division
Cc: Clients

CEHURD
social justice in health

CENTER FOR HEALTH, HUMAN RIGHTS & DEVELOPMENT
Plot 4008 Justice Road, Canaan Sites, Nakwero Gayaza-Kalagi Road
P.O. Box 16617 Wandegeya, Tel: 0414-532283
Email: info@cehurd.org Website: www.cehurd.org

Our Ref: CEHURD/ADMIN/4/29 *Date:* 13th April 2018

Your Ref:.....

HIGH COURT OF UGANDA
P.O. BOX 7085 KAMPALA
17 APR 2018
RECEIVED
SIGN:.....

"B"

The Executive Director
Mulago National Referral Hospital
Kampala

Dear Sir,

RE: Authorization to visit Mulago National Referral Hospital to follow up on implementation of the High Court decision in Civil Suit No. 212, CEHURD and Others vs. Executive Director, Mulago National Referral Hospital and the Attorney General

We are writing to request for your authorization to visit Mulago National Referral Hospital on the 25th day of April, 2018 to follow up the implementation of the above High Court decision.

On the 27th of January, 2017, the High Court of Uganda entered judgment in favour of the Plaintiffs and ordered inter alia that CEHURD should have "free access to Mulago Hospital and continuously oversee the steps taken by Mulago Hospital to enhance the respect, movement and safety of babies delivered dead or alive". Copy of the Court decree and Judgment are attached.

We are therefore writing to seek your authorization to visit Mulago National Referral Hospital on the 25th day of April, 2018 at 10.00am or any other date and time convenient for you.

We are looking forward to a positive response.

MULAGO HOSPITAL COMPLEX
17-4-18
RECEIVED

Sincerely,

Mulumba Moses
EXECUTIVE DIRECTOR

Cc: Registrar, High Court of Uganda - Civil Division
Cc: The Attorney General
Cc: Mr. Mubangizi Micheal and Ms. Musimenta Jennifer

MINISTRY OF JUSTICE & CONSTITUTIONAL AFFAIRS
DIRECTORATE OF CIVIL LITIGATION
17 APR 2018
RECEIVED
Sign:.....

THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

MULAGO NATIONAL REFERRAL HOSPITAL
DIRECTORATE OF OBSTETRICS AND GYNAECOLOGY

DIRECTORATE OF OBSTETRICS AND GYNAECOLOGY MANUAL

QUALITY MANAGEMENT SYSTEM ISO 9001

Document No: MNRH /DOB/OM/012

Issue No: 1

Revision No: 0

Effective Date: January 17, 2017

Republic of Uganda	MULAGO NATIONAL REFERRAL HOSPITAL			
	Document Title: Directorate of Obstetrics and Gynaecology Manual		**Document No:** MNRH /DOB/OM/012	
	Issue No: 1	**Revision No:** 0	**Effective Date:** January 17, 2017	
Prepared by: Sr. Bwongyezibwa K, Sr. Nabacwa Olivia N, Dr. Namagembe Imelda, Dr. Ntuyo Peter and others		**Reviewed by:** ISO CORE COMMITTEE	**Approved by: Dr. B.B. Byarugaba**	

Republic of Uganda	MULAGO NATIONAL REFERRAL HOSPITAL			
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This Manual has been prepared, reviewed and approved by the following persons to form part of the Quality Management System for Mulago National Referral Hospital:

Prepared by: Sr. Bwongyezibwa K, Sr. Nabacwa Olivia.N, Dr. Namagembe Imelda, Dr. Ntuyo Peter and others

Reviewed by: ISO Core Committee

Position:

Signature:

Date:

Approved by: Dr. B.B. Byarugaba

Position: Executive Director

Signature:

Date:

TABLE OF CONTENTS

ACRONYMS

AMTSL:	Active management of the third stage of labour
APGAR:	Appearance, Pulse, Grimace, Activity, Respiration.
BS:	Blood slide
CBC:	Complete Blood Count
GOPD:	Gynaecology Outpatient Department
Hb:	Haemoglobin
HDU:	High Dependency Unit
HIV:	Human Immuno-deficiency Virus
ICU:	Intensive Care Unit
JHO:	Junior House Officer
LFT:	Liver function test
MakCHS:	Makerere University College of Health Sciences
MFM:	Fetal Maternal Medicine
MNRH:	Mulago National Referral Hospital
MoU:	Memorandum of Understanding
NIRA:	National Identification and Registration Authority (NIRA).
NOK:	Next of Kin
PAC:	Post Abortion Care
PEP:	Post Exposure Prophylaxis
RFT:	Renal function test
SGBV:	Sexual and Gender Based Violence
SHO:	Senior House Officer
SMNHCU:	Specialized Maternal and Neonatal Health Care Unit
WHO:	World Health Organisation
YCC:	Young child clinic

1.0 INTRODUCTION

1.1 GENERAL

The Directorate of Obstetrics and Gynaecology is one of the seven directorates in Mulago National Referral Hospital (MNRH). This Directorate offers a wide range of Reproductive health services including patient care, training and research. It is divided into five departments namely: Maternal fetal medicine, Urogynaecology, Gynaecological oncology, General Gynaecology Reproductive medicine and family planning.

1.2 PURPOSE

This manual defines standards, processes, procedures and activities in the Directorate of Obstetrics and Gynaecology.

1.3 SCOPE

The manual will include all processes, procedures and activities that take place in the directorate.

1.4 DOCUMENT CONTROL

This operational manual shall be controlled according to "The Procedure for Control of Documented Information" (Ref: MNRH/OP/014).

1.5 RESPONSIBILITY

The Director/ Clinical head shall be responsible for the implementation and maintenance of this document.

1.6 REFERENCES

This manual shall be read together with the following documents:

Antenatal Health Care Guidelines (WHO Antenatal Health Care Guidelines)

Clinician's handbook

Clinical Notes (H.F. 303)

Consultation request form (H.F. 304)

Death protocol

Drug Administration Sheet

Elimination of Mother to Child Transmission (eMTCT) guidelines (WHO eMTCT guidelines)

Essential care of the newborn guidelines (Ministry of Health guidelines)

Face sheet (H.F. 302)

Facility follow-up protocol (MNRH protocol)

Intra Uterine Fetal Death (IUFD) guidelines (MNRH/DOG guidelines)

Laboratory request form (H.F. 307)

Labour monitoring guidelines (Ministry of Health)

Maternal and Child Death Audit (Ministry of Health Guidelines)

Medical Form 5 (MF 5)

Memorandum of Understanding between Mulago National Referral Hospital and Makerere College of Health Sciences Human resource manual

Ministry of Health, Mulago Hospital Gynaecology medical form (M. F. 116)

Mother and Child Care booklet (Ref: MoH/MNRH/OB/MCCB/010)

Mulago Hospital Discharge form

Necropsy request form (H.F.320)

PEP Guidelines (Ministry of Health)

Post Abortion Care Guidelines (WHO guidelines)

Post-delivery care guidelines (Ministry of Health)

Procedure for Control of Documented Information (Ref: MNRH/OP/014)

Procedure for Triaging (Ref: MNRH/OP/016)

Treatment sheet (H.F. 319)

Ultrasound request form (H.F. 312 (c))

Universal infection prevention and control guidelines (Ministry of Health, WHO)

Waste management guidelines (Ministry of Health, MNRH)

WHO Active management of third stage of labour guidelines

WHO guidelines on management of delivery

WHO guidelines on resuscitation of the newborn

WHO guidelines on safety surgical checklists

X-ray request form (H.F. 12 (a))

2. 0 DESCRIPTION OF ADMINISTRATION

The following administrative measures shall apply;

a. The directorate shall be headed by a Director/ Clinical Head from MNRH and he/she shall work in collaboration with the Head of Department from Makerere University College of Health Sciences (MakCHS).

b. The working relationship between the Directorate of Obstetrics and Gynaecology-MNRH and the Department of Obstetrics and Gynaecology - MakCHS shall be guided by the Memorandum of understanding (MoU) between MNRH and MakCHS.

c. Monthly and quarterly working schedules for all the specialists on all the wards/units shall be prepared by the Deputy Director. Quarterly schedules shall be made available 15 days before the beginning of the quarter while monthly schedules shall be available 1 week before the beginning of the month.

d. Monthly working schedules for all nurses and midwives shall be prepared by ward/unit In-charges.

e. Monthly and quarterly working schedules for Allied health professionals shall be prepared by the respective heads of the wards/units.

f. Monthly working schedules for Senior House Officers (SHO), Junior House Officers (JHO) and medical interns shall be prepared by the assigned persons.

g. In case of support staff, monthly working schedules shall be prepared by the respective heads of the units and shared with the Clinical Head and Head of Department of Obstetrics and Gynaecology.

h. The ward/unit In-charges shall be responsible for preparing weekly duty allocations for staff.

i. A daily attendance register shall be maintained for all staff by the Director/Clinical Head.

j. In case any staff is not available on duty for any reason at any time, the immediate supervisor shall find a replacement as soon as possible.

k. In case the replacement cannot be found, the area manager shall be informed for appropriate action.

l. No staff on duty shall leave the ward/unit without authorization from the immediate supervisor.

m. No staff shall leave duty at the end of the shift without a proper hand over to the incoming staff.

n. In the event that the incoming staff delays to report by 30 minutes, the staff handing over shall report to the shift supervisor.

o. Weekly review of the stock cards shall be done by the ward/unit In-charges to ensure accountability of medicines and sundries.

p. Daily ward reports shall be compiled by the nurses on night duty and submitted to the superintendent who shall in turn submit the report to the Assistant Commissioner Health Services (Nursing) in the presence of area managers.

q. Monthly, quarterly and annual reports shall be prepared by the Ward/unit In-charges, Area Managers and all Heads of Departments and submitted to the Director/Clinical Head.

r. Annual leave rosters and other forms of leave shall be handled and implemented in accordance with the human resource manual.

3.0 DESCRIPTION OF PROCESSES

3.1 TRIAGE

Triaging is the process of sorting patients according to the severity of their conditions and urgency of need for care. This shall be done to ensure that the person with the most urgent need gets care first. Triaging shall be conducted in accordance with the provisions of the Procedure for Triaging (Ref: MNRH/OP/016).

3.2 OUT-PATIENT CARE

This is the care given to Clients/patients in the Out-patients' set up.

a. Patients shall be welcomed and received by the customer care officer and directed to triage midwife/nurse.
b. The triage midwife/nurse shall ask for the referral letter and then document vital observations of the client/patient.
c. The client/patient shall be given a colour code according to the triage category. RED- for a patient who needs very urgent attention; YELLOW- for urgent attention; GREEN- can wait.
d. The records officer shall register the client/patient data after triage.
e. The triage nurse/midwife shall consent the patient. In case the patient's condition does not allow her to consent, the NOK shall consent on her behalf.
f. In case of a high risk patient (RED or YELLOW), the nurse/midwife shall accompany and handover the patient to the doctor in charge of the receiving team.
g. The doctor in charge of the receiving team shall carry out a quick assessment and make a working diagnosis and any emergency treatment required shall be given by the nurse/midwife.
h. The doctor shall explain the medical condition to the patient/caretaker and the investigations required.

i. The doctor shall request for the investigation(s) and this shall be documented on the appropriate request forms and dully signed.

j. The patient shall be sent to diagnostic unit for the investigations. In case the patient is very sick she shall be accompanied by the nurse/ midwife.

k. The diagnostic unit staff shall send the results to the requesting doctor.

l. The management plan shall be made by the doctor based on clinical diagnosis and investigations.

m. The nurse/midwife shall give the prescribed treatment to the patient.

n. The patient shall be counseled by the doctor, nurse/midwife or counselor accordingly.

o. The nurse/midwife shall health educate the patient/caretaker about the patient's condition.

p. The patient shall be given a follow-up plan by the doctor or nurse/midwife according to the follow-up protocol.

q. In case a patient requires admission, the doctor shall explain to the patient the need for admission, complete the admission documents and hand over the file to the nurse/midwife.

r. The nurse/midwife shall communicate to the appropriate ward to make preparation for admitting the patient.

s. The recipient ward shall communicate availability of the bed for admission and the doctor shall be informed accordingly.

t. In case the patient chooses a no treatment option, she shall be required to document it in the file (face sheet).

u. In case a decision to operate the patient is taken, the attending doctor shall book the patient for theatre according to her condition.

3.3 ANTENATAL CARE

This is a care given to pregnant women to identify and attend to high risk conditions and to prepare for safe delivery. Pregnant women shall be encouraged to attend antenatal clinics with their husbands/partners.

a) When a client presents to the Antenatal clinic, 2.2 (a)-(f) above shall apply
b) Emergency cases shall be identified and transferred to an appropriate Emergency Ward and the case shall be handled accordingly.
c) Group health education shall be conducted for low risk clients in accordance with Antenatal Health Care Guidelines (Refer to the WHO Antenatal Health Care Guidelines).
d) The low risk clients shall be counselled for routine blood testing, receipt of results and any other related psycho-social issues.
e) In case the husband/partner is present, counselling shall be provided to the couple.
f) Routine blood tests shall be conducted in accordance with Antenatal Health Care Guidelines.
g) The nurse/midwife shall take history, conduct a physical examination of the client to track the condition of the mother and the fetus, and the findings shall be documented in the Mother and Child Care booklet (Ref: MoH/MNRH/OB/MCCB/010) and communicated to the client.
h) The nurse/midwife shall listen to and discuss concerns of the client if any.
i) The nurse/midwife shall ensure that the results of routine blood tests such as HIV and Syphilis are communicated to the client.
j) The nurse/midwife may request for further investigations or consult a doctor as may be considered appropriate.
k) The nurse/midwife shall make a diagnosis, prescribe medication, schedule appointment for subsequent visit, and these shall be agreed upon with the client.

l) In case of a newly diagnosed HIV positive client, the nurse/midwife shall send the patient to the specialized counsellor and doctor for further counselling and initiation of antiretroviral therapy.

m) The nurse/midwife shall update the client's file accordingly.

n) The client shall be sent to the pharmacy to collect the medication.

o) The client who is at term shall be advised to report to the hospital immediately she observes signs of labour.

p) The client who is in labour shall be admitted in the labour ward.

q) At the end of the clinic, the nurse/midwife shall compile the schedules for subsequent visits and clients shall be reminded at least 2 days prior to the scheduled date.

3.4 IN-PATIENT CARE

3.4.1 NON EMERGENCY OBSTETRIC PATIENT CARE

The following shall apply:

a. The client shall be welcomed and received by the midwife in charge of admissions in the labour suite.

b. The admitting midwife shall register and update the client's bio-data in the Mother and Child Care Booklet (Ref: MoH/MNRH/OB/MCCB/010)

c. The admitting midwife shall allocate a bed to the client.

d. The admitting midwife shall hand over the client to the attending midwife.

e. The attending midwife shall measure immediate and subsequent vital parameters and document them in the Mother and Child Care Booklet (Ref: MoH/MNRH/OB/MCCB/010).

3.5 INTRAPARTUM CARE

This is a care given to pregnant women during the process of labour and delivery. The delivery can be normal, assisted vaginal or caesarean section. The labour process is monitored using a partograph.

The following shall apply:

a. The admitting midwife in the labour ward shall receive the client in labour.

b. The midwife shall read through the client's antenatal or referral notes.

c. The midwife shall triage the client by taking a brief history of labour and the vital observations such as blood pressure, pulse, respirations and temperature. This shall be documented in the Mother and Child Care Booklet (Ref: MoH/MNRH/OB/MCCB/010).

d. The midwife and/or Doctor shall obtain an informed consent from the client /caretaker

e. The Doctor and/or midwife shall carry out a physical examination of the client to ascertain the condition of the client and the fetus.

f. The midwife and/or the doctor shall make a provisional diagnosis and management plan.

g. The doctor and/or midwife shall document findings in the Mother and Child Care Booklet and the findings shall be communicated to the client/care taker.

h. The doctor shall request for routine and any other investigations as deemed necessary.

i. The laboratory technician shall take off the samples as requested.

j. In case the investigations require the client to be taken to the respective Diagnostic unit, the midwife shall accompany the client.

k. The results from the relevant investigations shall be handed over to the midwife and/or doctor.

l. The doctor shall review and discuss the results with the attending team and the diagnosis and management plan shall be updated accordingly.

m. The client who is diagnosed to be in labour shall be admitted by the midwife to the respective stage of labour and her Mother and Child Care Booklet shall be updated.

n. The client in latent phase of the first stage of labour shall be monitored in accordance with the labour monitoring protocol.

o. The midwife shall monitor the condition of the fetus and the mother in active phase using a partogram.

p. The midwife shall constitute a team to prepare to conduct the delivery of the client.

q. The midwife shall continue monitoring the condition of the fetus and the mother in labour until when there are signs of second stage.

r. When the client becomes fully dilated, the midwife or doctor shall inform the client that the delivery of the baby is due.

s. In case the client's condition requires resuscitation, the midwife and/or doctor shall CALL for help and the client shall be resuscitated according to the protocol on resuscitation

t. The midwife shall inform the doctor of any complication(s) that arise such as delay in the different stages of labour and the doctor shall manage in accordance with the relevant protocols (Refer to prolonged labour, obstructed labour, antepartum haemorrhage, intrapartum haemorrhage, ruptured uterus protocols).

u. The midwife and/or doctor shall convene the delivery team and commence on the delivery process.

v. A midwife on the delivery team shall continue carrying out vital observations of the client and the fetus.

w. The client shall be updated about the progress of labour at all stages.

x. At the delivery of the baby, the baby shall be placed on the mother's abdomen in prone position. The midwife shall note the time of delivery and document it in the Mother and Child Care Booklet.

y. The midwife will then use a cotton cloth (towel) to dry the baby as well as stimulate breathing by rubbing, according to the Helping the Baby Breathe protocol (HBB) (Ref: MoH/OB/HBB).

z. The midwife will use a second cotton cloth (towel) to keep the baby warm according to the Helping the Baby Breathe protocol (HBB).

aa. The midwife shall clamp the cord (4 cm from the navel) of the baby who has established normal breathing and this shall be done within 3 minutes. In case the baby fails to breathe, the baby shall be managed according to the HBB protocol and the special care unit alerted.

bb. In case the baby does not respond to the HBB protocol, the baby shall be transferred to the special care unit by the midwife.

cc. The midwife shall cut the cord 2cm above the clamp (6cm from the navel).

dd. The midwife shall administer an intramuscular (IM) injection 10 IU of oxytocin to the mother's anterior thigh.

ee. The midwife shall determine the baby's APGAR score at one and five minutes after delivery.

ff. The midwife shall show the baby to the mother who shall confirm the sex of the baby.

gg. The midwife shall deliver the placenta (third stage of labour) according to the AMSTL protocol (WHO AMSTL guidelines).

hh. The midwife shall examine the placenta, check for and repair any vaginal tear(s).

ii. The midwife shall clean the mother, note the amount of blood loss and ensure that the mother is comfortable.

jj. The midwife shall carry out the first examination of the newborn including taking the birth weight of the baby within one hour after delivery.

kk. The midwife shall clear away and dispose off the waste in accordance with the WHO Hospital waste management guideline.

ll. The midwife shall assist the mother to initiate breastfeeding within the first 30 minutes after birth.

mm. The midwife shall document all the intrapartum care in the mother's file.

nn. The midwife/nurse shall administer the prescribed treatment to the mother.

3.6 POSTPARTUM CARE

This is a care given to women and new born babies immediately after delivery up to 42 days. It involves monitoring of delivered women and babies to identify danger signs indicative of postpartum haemorrhage, puerperal sepsis, postpartum eclampsia in the mother and asphyxia, neonatal sepsis in the newborn.

In case of normal delivery the following shall apply:

a. The midwife shall transfer the mother to the postpartum room where she shall spend about 2 hours and monitored according to the Ministry of Health guidelines on post-delivery care.
b. The midwife shall carry out the care of the newborn in accordance with the Essential care of the newborn guidelines.

c. If the condition of the mother and the newborn is satisfactory, the midwife in the postpartum room shall transfer the mother and the baby and hand them over to the midwife in the postnatal ward.

d. The midwife in the postnatal ward shall monitor the mother and baby for 24 hours before they are discharged. The discharge protocol shall apply.

In case of a caesarean section the following shall apply:

a. Clauses 2.3.1. (a) – (e) for inpatient services shall apply.

b. The midwife from recovery section of theatre shall hand over the mother to the postnatal midwife with documentation in the patient's Mother and Child Care Booklet indicating at least two names of the patient, type of operation done, duration of operation, recent blood pressure, pulse rate, SPO_2 and respiratory rate.

c. The midwife shall ensure that post-operative pain is adequately managed.

d. The receiving midwife shall ascertain that the uterus is well contracted and ensure that there is no active bleeding from the vagina.

e. The midwife shall transfer the mother (with no active bleeding) and her baby to the **ZERO** post-operative section of the postnatal ward.

f. In case the midwife identifies active vaginal bleeding, the doctor shall be informed immediately and the mother shall be retained in the recovery room in theatre and managed as per the PPH protocol.

g. Where special monitoring of vital parameters is required this shall be indicated and communicated to the receiving midwife.

h. In case of a sick newborn (severe birth asphyxia, sepsis), the baby shall be taken to NICU/SCU after communicating to the team.

i. In the event of a still birth, the baby shall be transferred to the mortuary for postmortem and a provisional death certificate shall be issued by the Department of Pathology.

j. The midwife on the postnatal ward shall monitor and document vital signs (Blood pressure, pulse rate, respiratory rate, SPO_2, vaginal bleeding, temperature) half hourly for the first 2 hours. If the vital signs are normal, monitoring shall continue every after one hour for the next 12 hours. This shall be documented in the vital signs chart (H.F 318).

k. The midwife shall monitor and document the fluid intake and output in the fluid balance chart (H.F 315a).

l. The doctor shall review the post-operation patients within 4 hours after the operation and update the treatment sheet (H.F.319).

m. The midwife/nurse shall administer the treatment and this shall be documented on the drugs administration record.

n. The patient shall be reviewed during the scheduled ward rounds (3 in a day) conducted by doctors and midwives to assess progress of recovery.

o. A doctor may request for investigations that shall be written on the appropriate request forms.

p. In case of abnormal vital sign(s), the midwife shall inform the doctor immediately while she/he institutes treatment.

q. The doctor shall review the patient in (o) above and manage her appropriately.

r. The doctor may recommend admission of the mother to HDU/ICU for further care and this shall be communicated to the HDU/ICU.

s. The baby shall be kept warm by the mother's side all the time.

t. Essential care of the new born shall be provided in accordance with the Ministry of Health guidelines on essential newborn care.

u. Breast feeding shall be initiated within the first one hour of delivery.

v. In case the mother's condition does not allow initiation of breastfeeding as in (u) above, alternative methods of feeding shall be used.

w. In case the baby is born to an HIV exposed mother, treatment shall be given in accordance with Elimination of Mother to Child Transmission (eMTCT) guidelines (MoH policy on eMTCT).

x. The midwife shall ensure that the baby is vaccinated with BCG, Polio O, and given Vitamin A within 24 hours of delivery.

y. A mother who has had a still birth shall be transferred to the designated section on the postnatal ward where management shall be in accordance with the institutional Intra Uterine Fetal Death (IUFD) guidelines (Ref: MNRH/OB/ IUFD guidelines).

z. A team comprising of a midwife, nutritionist and paedriatric nurse shall give health education on the following: early recognition of danger signs of the new born and the mother; feeding; family planning to the woman and partner where available before discharge.

aa. All mothers with babies in NICU/ SCU shall be health educated by the midwife, nutritionist and Paediatric nurse on essential care of the newborn.

bb. The patient with infectious conditions such as Tetanus, Hepatitis, Tuberculosis, Ebola or with puerperal sepsis shall be admitted in isolation section of the ward and managed according to specific WHO guidelines.

cc. A mother who is Blood group Rhesus negative shall be given a deep intramuscular injection of 300ug of Anti-D Immunoglobulin within the first 72 hours post delivery.

dd. A mother identified with occupational needs shall be reviewed by the Occupational Therapist on the postnatal ward before discharge.

ee. A mother with psychosocial needs shall be identified and reviewed by the social worker.

ff. A mother with medical complications such as PET/Eclampsia, cardiac disease, Diabetes Mellitus, sickle cell disease shall be managed in accordance with the appropriate protocols.

gg. A mother with medical condition other than PET/Eclampsia, consultations to the interdisciplinary team shall be made using the consultation request form (H.F. 301) within 24 hour of admission on the postnatal ward.

hh. The ward In-charge shall ensure that the universal infection control and prevention practices are observed by all health care providers, support staff and visitors on the ward.

ii. The midwife In-charge shall take charge of the ward to ensure that all patients are reviewed and managed according to protocols.

jj. All mothers who have had vaginal birth and in good condition shall be discharged by the midwife within 24 hours after delivery. The discharge protocol shall apply.

kk. All mothers who deliver by C/S and are without complications shall be discharged on the 3rd day by the doctor/SHO on duty. The discharge protocol shall apply.

ll. In case of complications after Caesarean section, the patient shall be management by the attending team until recovery.

mm. A mother who had a vaginal delivery shall be reviewed after 6 days by the midwife in the Hospital's low risk post-natal clinic or Domiciliary services in the community.

nn. A mother who had been delivered by caesarean section shall be reviewed by the doctor from the Hospital's high risk post-natal clinic on the 7th post-operative day or earlier in case of complications.

oo. A mother who delivered and is in good general condition, shall have the next review at 6 weeks and later at six months in the Family planning clinic and young child clinic (YCC).

pp. All postnatal mothers shall be referred to the Family planning clinic for cervical cancer screening at 12 weeks postpartum. In case of a positive visual inspection with acetic acid (VIA) the mother shall be referred to the colposcopy room for Cryo-therapy, Colposcopy and Loop Electro Excision Procedure (LEEP).

3.7 NON-EMERGENCY GYNAECOLOGICAL CARE

The following shall apply:

a. The patient shall be welcomed and received by the nurse/midwife in charge of admissions in the Gynaecology ward.
b. The admitting nurse/midwife shall register and update the patient's bio-data on the Ministry of Health, Mulago Hospital Gynaecology medical form (M. F. 116).
c. The admitting nurse/midwife shall allocate a bed to the patient.
d. The admitting nurse/midwife shall hand over the patient to the attending nurse/midwife.

e. The attending nurse/midwife shall measure immediate and subsequent vital parameters and document them on the Ministry of Health, Mulago Hospital Gynaecology medical form (M. F. 116).

f. The Records Officer shall open up a file for the patient.

g. The doctor and the nurse/midwife shall carry out clinical assessment of the patient by carrying out history taking, physical examination and measurement of vital observations, and this shall be documented in the clinical notes (H.F. 303).

h. The doctor shall request for general and specific investigations depending on the patient's condition and these shall be documented in the respective request forms.

i. In case an investigation report cannot be obtained within 24hours, the diagnostic unit shall be contacted by the unit In-charge.

j. The doctor shall make a provisional diagnosis and any consultations made shall be written on the consultation request form (H.F. 304).

k. The doctor shall prescribe treatment accordingly and this shall be documented on the treatment sheet (H.F. 319).

l. The nurse/midwife shall administer the prescribed treatment and document on the Drug Administration Sheet.

m. The doctor shall receive and review the investigation reports and confirm or update the diagnosis accordingly.

n. In case pending investigations require the patient to be taken to the diagnostic unit, the patient shall be accompanied by a nurse/midwife.

o. In case the diagnosis requires consultation, the doctor shall fill in the consultation request form (H.F. 304) and this shall be delivered to the specialist.

p. In case of a specific procedure or surgery, the doctor shall explain and consent the patient. Preparation for surgery shall be done as in clause 2.5.

q. The decision to discharge the patient shall be made by the attending doctor upon ascertaining that the patient has improved. The procedure for discharge shall be as in 2.4.1.1.

3.8 EMERGENCY CARE

This is the process that provides quick and lifesaving procedures. It is divided into emergency gynecology and obstetrics care.

3.8.1 EMERGENCY GYNAECOLOGY CARE

The following shall apply:

a. The customer care team shall receive the patient and her next of kin (NOK) and hand her over to the triage team.
b. The triage nurse/midwife shall check the referral letter to evaluate the nature of the referral.
c. The Records Officer shall open up a file for the patient.
d. In case the patient had been admitted before, the old file shall be retrieved.
e. The nurse/midwife on the triage team shall consent the patient.
f. In case the patient's condition does not allow her to consent as in 2.4.1(c.) above, the NOK shall consent on her behalf. A minor shall sign an assent.
g. The doctor on the triage team shall carry out a quick clinical assessment of the patient's condition and document the findings.
h. In case the patient needs resuscitation she shall be rushed to the resuscitation room and managed by the resuscitation team.
i. The doctor shall briefly explain to the patient/caretaker about the condition.
j. The doctor and the nurse/midwife shall carry out clinical assessment of the patient by carrying out history taking, physical examination and measurement of vital observations, and this shall be documented in the clinical notes (H.F. 303).

k. The doctor shall request for general and specific investigations depending on the patient's condition and these shall be documented in the respective request forms.

l. In case an investigation report cannot be obtained within 24hours, the diagnostic unit shall be contacted by the unit In-charge.

m. The doctor shall make a provisional diagnosis and any consultations made shall be written on the consultation request form (H.F. 304).

n. The doctor shall prescribe treatment accordingly and this shall be documented on the treatment sheet (H.F. 319).

o. The nurse/midwife shall administer the prescribed treatment and document on the Drug Administration Sheet.

p. In case of a specific procedure or surgery, the doctor shall explain and consent the patient. Preparation for the surgery shall be done according to clause 2.5.

q. Communication about admission of the patient shall be made to the admitting ward by the nurse/midwife.

r. The nurse/midwife shall accompany the patient to the admitting ward.

s. The doctor shall review the management plan and update it accordingly.

t. The record officer shall document/update details of the patient's data.

u. The doctor shall receive and review the investigation reports and confirm or update the diagnosis accordingly.

v. In case pending investigations require the patient to be taken to the diagnostic unit, the patient shall be accompanied by a nurse/midwife.

w. In case the diagnosis requires consultation, the doctor shall fill in the consultation request form (H.F. 304) and this shall be delivered to the specialist.

x. A patient who may require special treatment such as Post Exposure Prophylaxis (PEP) and Post Abortion Care (PAC) shall be managed in accordance with PEP (MoH guidelines) and PAC Guidelines (WHO guidelines) respectively.

y. The decision to discharge the patient shall be made by the attending doctor upon ascertaining that the patient has improved. The discharge procedure shall be done as in 2.4.1.1.below

z. In case of death of the patient, the procedure 2.4.1.2 shall apply.

3.8.1.1 DISCHARGE OF A PATIENT

a. On recovery, the attending team shall prepare the patient for discharge.

b. The discharging doctor shall communicate to the patient/attendant the decision to discharge the patient.

c. The discharging doctor shall duly fill in the inpatient discharge form (Ref: MNRH Inpatient Discharge Form).

d. The doctor shall issue the discharge form to the patient and shall explain the details of the discharge and follow- up plans at the time of discharge.

e. The nurse/midwife In-charge shall explain the discharge instructions to the patient and/or NOK and shall administer the prescribed medication before the patient leaves the ward.

f. The nurse/midwife In-charge shall handover the discharge form to the patient or his/her attendant.

g. The patient shall be followed up (reviewed) from the parent clinic or other relevant clinics in line with the follow up plans.

h. In case a referral to another facility (within or outside the country) is required, the referral protocol shall apply. The attending doctor shall then write a referral note for the patient accordingly.

3.8.1.2 DEATH OF A PATIENT

The following shall apply:

a. The doctor shall confirm and certify the death.

b. The attending team shall convene and inform the N.O.K and/ or the family.

c. The nurse/midwife shall carry out last office, register the death and inform mortuary staff.

d. The doctor shall request for a necropsy to be done by filling in the necropsy request form (H.F.320). However, he/she may issue a provisional death certificate for patients who have been in the ward for at least 24 hours.

e. The doctor shall fill in the death notification form which shall be submitted to the Maternal and Perinatal Death Review Committee within 24 hours.

f. The nurse/midwife shall hand over the body to the mortuary attendant who will sign in the death register book and transfer the body to the mortuary.

g. A necropsy report shall be required for all deaths in the best interest of improving patient care and for legal purposes.

h. In case the NOK/relative of the deceased objects to performing a necropsy, such an objection shall be put in writing and addressed to the Executive Director stating clearly the reasons for the objection, and the final decision shall be made by the Executive Director.

i. The attending team shall audit the death and submit the audit report to the Maternal and Perinatal Death Review Committee within seven (7) days.

j. The death certificate shall be provided by National Identification and Registration Authority (NIRA).

3.8.2 EMERGENCY OBSTETRIC CARE

The following shall apply:

a. The customer care team shall receive the patient and her next of kin (NOK) and hand her over to the triage team.

b. The triage midwife shall check the referral letter to evaluate the nature of the referral.

c. The Records Officer shall open up a file for the patient. Data shall also be captured electronically.

d. In case the patient had been admitted before, the old file shall be retrieved.

e. The midwife on the triage team shall consent the patient.

f. In case the patient's condition does not allow her to consent as in 2.4.1(e.) above, the NOK shall consent on her behalf. The emancipated minor shall consent.

g. The midwife on the triage team shall carry out a quick clinical assessment of the patient's condition and document the findings in the Mother and Child Care Booklet (Ref: MoH/MNRH/OB/MCCB/010).

h. In case the patient needs resuscitation she shall be rushed to the resuscitation room and managed by the resuscitation team.

i. The midwife shall briefly explain to the patient/caretaker about the condition.

j. The doctor and the midwife shall carry out clinical assessment of the patient by carrying out history taking, physical examination and measurement of vital observations, and this shall be documented in the clinical notes (H.F. 303).

k. The doctor shall request for general and specific investigations depending on the patient's condition and these shall be documented in the respective request forms.

l. In case an investigation report cannot be obtained within 24hours, the diagnostic unit shall be contacted by the unit In-charge.

m. The doctor and the midwife shall make a provisional diagnosis and any consultations made shall be written on the consultation request form (H.F. 304).

n. The doctor shall prescribe treatment accordingly and this shall be documented on the treatment sheet (H.F. 319).

o. The midwife shall administer the prescribed treatment and document on the Drug Administration Sheet.

p. In case of a specific procedure or surgery, the doctor and midwife shall explain and consent the patient. Preparation for the surgery shall be done according to clause 2.5.

Communication about admission of the patient shall be made to the admitting ward by the nurse/midwife.

q. The midwife shall accompany the patient to the admitting ward.

r. The doctor shall review the management plan and update it accordingly.

s. The record officer shall document/update details of the patient's data.

t. The doctor shall receive and review the investigation reports and confirm or update the diagnosis accordingly.

u. In case pending investigations require the patient to be taken to the diagnostic unit, the patient shall be accompanied by a midwife.

v. In case the diagnosis requires consultation, the doctor shall fill in the consultation request form (H.F. 304) and this shall be delivered to the specialist.

w. A patient who may require special treatment such as Post Exposure Prophylaxis (PEP) shall be managed in accordance with PEP (MoH PEP guidelines).

x. The decision to discharge a patient who has had a normal delivery shall be done by the midwife. The discharge procedure shall be done as in 2.4.1.1.

y. Other than the normal delivery as in (w) above, the decision to discharge the patient shall be made by the attending doctor upon ascertaining that the patient has improved. The discharge procedure shall be done as in 2.4.1.1.

z. In case of death of the patient, the procedure 2.4.1.2 shall apply.

3.9 PREPARATION OF A PATIENT ON THE WARD

Patients who need operations shall be prepared from the wards. Preparation shall be done for two categories of operations; emergency and elective operations as described below:

3.9.1 EMERGENCY OPERATIONS

All emergency operations shall be carried out as follows:

a. The attending doctor shall:
   i) Identify patients who need emergency operation at admission or during review.
   ii) Ensure that basic investigations such as CBC, RFTs, 12 Lead ECG, RBS, grouping and cross matching are done in preparation for operation.
   iii) Explain and re-assure the patient/NOK about the operation to be done and the attending doctor shall work closely with the nurse allocated for theatre.
   iv) Ensure that an informed consent/assent is obtained from the patient/NOK.

b. The attending doctor shall make a list of patients to be operated.
c. The theatre list shall be updated by the doctor in case of new emergencies.
d. The anaesthetist shall review the patient and make a recommendation which may include proceeding with operation, resuscitation, administration of medications or staying the operation.
e. The ward/unit In-charge shall hand over the theatre list to the theatre In-charge.
f. The theatre In-charge shall acknowledge receipt of the theatre list by signing on the list.
g. A signed theatre list shall be retained and displayed in the theatre and a copy shall be returned to the ward.
h. The ward nurse responsible for operations shall prepare the patient for theatre including dressing the patient in a theatre gown.
i. The ward nurse responsible for operations shall ensure that pre-operative observations are done and the theatre safety surgical check list is filled as per the WHO guidelines on safety surgical checklists.
j. The responsible ward midwife/nurse shall take the patient to theatre and hand her over to the receiving midwife/nurse in the theatre.

3.9.2 ELECTIVE OPERATIONS

a. The attending doctor shall:
   i) Identify a patient who needs operation during review on the ward.
   ii) Determine and ensure that appropriate investigations are done and results received.
   iii) Book the patients for theatre.
   iv) Explain and re-assure the patient/NOK about the operation to be done and the attending doctor shall work closely with the midwife/nurse allocated for theatre.
   v) Ensure that an informed consent is obtained from the patient/NOK.
   vi) Make a list of patients to be operated and forward it to the ward In-charge.

b. The anaesthetist shall review the patient and make a recommendation which may include proceeding with operation, resuscitation, administration of medications or deferring the operation.

c. The ward In-charge shall ensure that the theatre list is delivered to the theatre at least 24 hours before the operation.

d. The theatre In-charge shall acknowledge receipt of the theatre list by signing on it.

e. A signed theatre list shall be retained and displayed in the theatre and a copy shall be returned to the ward.

f. The ward midwife/nurse responsible for operations shall ensure that pre-operative observations are done and the theatre safety surgical check list is filled.

g. The ward midwife/nurse responsible for operations shall prepare the patient for theatre.

h. The ward midwife/nurse responsible for operations shall take the patient and hand her over to the receiving midwife/nurse in theatre.

3.10 THEATRE SERVICES

The following shall apply to all operating procedures in the theatre:

3.10.1 PRE-OPERATIVE CARE

a. The theatre In-charge shall communicate the readiness for the operation to the ward 30 minutes before the scheduled time.
b. The instrument/scrub midwife/nurse shall prepare the operation set on the trolley.
c. The anesthetist shall prepare the anesthetic drugs and other relevant equipment.
d. Upon receiving the patient from the ward, the details of the patient shall be recorded by the receiving midwife/nurse and the record shall include the signatures of both the receiving and the handing over midwife/nurse.
e. The receiving midwife/nurse shall make a quick review of the patient in accordance with the theatre safety surgical checklist.
f. The surgeon and the anaesthetist shall review the patient.
g. The patient shall then be wheeled to the operating room.
h. The operating team shall prepare for operation in accordance with the WHO checklist.
i. The anaesthetist together with the operating team shall put the patient on the operation table and ensure that the patient is in a position that is appropriate for surgery. They shall continuously re-assure the patient.
j. The anesthetist shall give relevant instructions to the patient.
k. The surgeon and his/her assistant, scrub/instrument midwife/nurse shall scrub and dress to be ready for the operation.
l. The instrument midwife/nurse shall count loud the mops, swabs, needles, blades, instruments before the operation.
m. The runner midwife/nurse shall document on the board the counted instruments, swabs, mops, needles, blades.
n. The theatre In-charge shall ensure that the midwife to receive the baby is available and well prepared.

o. The anesthetist shall take the pre-anaesthetic vital signs and then administer the anesthetic drugs.

3.10.2 INTRA-OPERATIVE CARE

The following shall apply:

a. The anesthetist shall carry out close monitoring of the patients' condition and shall document the vital parameters throughout the operation.
b. The runner midwife/nurse shall be giving assistance where need be.
c. Instruments, mops, swabs, needles, and blades shall be counted loudly to the entire team by the instrument/scrub midwife nurse BEFORE closure of the open body part.
d. The runner nurse shall continuously record all the instruments mops, swabs, needles, and blades requested and used during the operation and the operating team shall confirm that all of these are recorded are accounted for.
e. Instruments, mops, swabs, needles, and blades shall be counted loudly to the entire team by the instrument/scrub midwife nurse AFTER closure of the open body part.
f. The surgeon shall confirm that the surgical operation has been done as planned and thereafter the surgeon shall declare the operation complete.
g. In case emergency procedures have been performed, they shall be documented and communicated to the patient or NOK as soon as possible.
h. In the event that an emergency procedure is to be performed, the NOK shall be invited in theatre to witness the condition to justify the unplanned procedure.
i. In case of caesarean section, the receiving midwife shall receive the baby, and physically present the sex, APGAR score, birth weight of the baby and time of delivery to the surgical team and the mother in case she is awake. All the details of the baby shall be documented in the file and birth register.

j. An identification tag shall be placed on the baby's wrist.

k. In case the condition of the baby requires resuscitation, the receiving midwife/nurse shall resuscitate the baby according to the HBB protocol or Newborn resuscitation protocol or seek help from the neonatologist and anaesthetist.

l. In case of congenital anomalies detected before or during surgery, the anomaly shall be documented and consultations shall be made as is appropriate.

3.10.3 POST OPERATIVE CARE

a. The surgeon and the anesthetist shall continuously monitor the patient. If the patient's condition is stable, the anaesthetist shall in consultation with the surgeon make a decision to transfer the patient to the recovery room.

b. The anaesthetist together with the runner midwife/nurse shall take and hand over the patient to the recovery midwife/nurse in the recovery room.

c. The surgeon shall record the operation details in the operation register and shall document detailed operation notes in the patients file which shall include, what was found, done, challenges encountered and postoperative management.

d. In case the patient's condition fails to stabilize within the predetermined recovery time or if complications arise, the surgeon shall make appropriate consultations and decisions which may include further surgery or transfer to ICU or HDU.

e. In the event of death in theatre, the death protocol shall apply (see clause 2.4.1.2).

f. In the event that a mother dies before surgery and the fetus is alive, an emergency postmortem C/S shall be performed immediately.

3.10.4 RECOVERY ROOM CARE

a. The recovery midwife/nurse together with the anaesthetist shall closely monitor the patient and document accordingly. Any deviation from the normal shall be quickly reported to the surgeon.
b. In case the surgeon determines that the patient is fit to be taken back to the relevant ward, the ward midwife/nurse shall be informed.
c. The recovery midwife/nurse shall hand-over the patient to the ward midwife/nurse.
d. The ward midwife/nurse shall make a quick assessment of the patient and take vital observations before transferring the patient from the theatre.
e. The ward midwife/nurse shall transfer the patient to the ward.
f. The instrument nurse shall clear the trolley and the dirty instruments and linen shall be treated in accordance with the WHO universal infection prevention and control guidelines.
g. The instrument midwife/nurse shall ensure proper waste segregation and disposal.
h. The theatre shall be cleaned according to the WHO universal infection prevention and control guidelines.
i. Neither the midwife/nurse, anaesthetist/doctor shall leave the duty station without handing over to the incoming members for the next duty.

3.11 INFECTION PREVENTION

The following shall apply:

a. All operations shall be carried out according to WHO universal infection and prevention guidelines.
b. The instrument midwife/nurse shall clear the trolley and the dirty instruments and the linen shall be cared for according to the WHO universal infection prevention guidelines.

c. The instrument midwife/nurse shall ensure proper waste segregation and disposal.

d. The theatre shall be cleaned according to the WHO universal infection prevention guidelines.

Dalumba Advocates

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21 June 2017

MINISTRY OF JUSTICE & CONSTITUTIONAL AFFAIRS
DIRECTORATE OF CIVIL LITIGATION
★ 21 JUN 2017 ★
RECEIVED
Sign:.....

DALUMBA/06/30

The Executive Director
Mulago National Referral Hospital
Kampala

Dr Byaruhanga Baterana,

RE: Implementation of the Judgment in Civil Suit No 212 of 2013 CEHURD & Ors V Attorney General and ED, Mulago

We act for and on behalf of the Center for Health Human Rights and Development, Mubangizi Michael and Musimenta Jennifer (CEHURD) on whose behalf we address you as hereunder.

On January 24, 2017, our clients received judgment in which you were ordered by Court to:

a) Hold Ms Mandida Mariam accountable for the movement of the baby from her care
b) Take steps to ensure and/or enhance the respect, movement and safety of babies, dead or alive at Mulago Hospital and report to Court every four months for two years regarding the steps taken.
c) Deliver to CEHURD all reports submitted to court to enable them oversee the implementation of the orders and make counter reports
d) Pay for psychosocial care and counselling for Mubangizi Michael and Musimenta Jennifer
e) Pay to Mubangizi Michael and Musimenta Jennifer Ug. Shs: 85,000,000/= (Eighty five million only) as general damages.

Our client has approached you to explore collaborative avenues of implementing these orders but you have ignored their requests. (Last correspondence is attached here)

We request you to report to us within five working days of receiving this letter about the efforts you have made in fulfilment of the orders of court above.

Should you fail to provide any report on the implementation of the orders of court, we have instructions to move court to institute contempt of court proceedings against you personally, and execution proceedings against the property of Mulago National Referral Hospital.

For DALUMBA ADVOCATES
Cc: Our Clients
Cc: The Attorney General of Uganda

Telephone: +256-414-554008/1
Fax: +256-414-5325591
E-mail: admin@mulago.or.ug
Website: www.mulago.or.ug

IN ANY CORRESPONDENCE ON THIS SUBJECT PLEASE.QUOTE NO.**D/GC/130**

MULAGO NATIONAL REFERRAL HOSPITAL
P.O. Box 7051
KAMPALA, UGANDA

THE REPUBLIC OF UGANDA

13th August, 2018

The Managing Partner
Dalumba Advocates,
P.O. Box 16617, Wandegeya
Kampala

Dear Sir,

PAYMENT OF GENERAL DAMAGES

Reference is made to your letter dated 29th May, 2018 referenced as DALUMBA/05/23 requesting Mulago National Referral Hospital to pay general damages awarded by the High Court amounting to Eighty Five Million Uganda Shillings (85,000,000/=) in respect of High Court Civil Suit No. 212 of 2013, CEHURD and 2 others vs Executive Director, Mulago National Referral Hospital and another.

We will make the payment in four installments by way of transfer to your account as provided to us. The payment schedule is highlighted below;

1. First payment of 25,000,000/= - Between 1st July and 30th September 2018
2. Second payment of 20,000,000/= - Between 1st October and 31stDecember 2018
3. Third payment of 20,000,000/= -Between 1st January and 31stMarch 2019
4. Final payment of 20,000,000/= - Between 1st April and 30th June 2019

We are looking forward to a positive collaboration.

Yours sincerely,

Dr. B. B. Byarugaba
EXECUTIVE DIRECTOR

Copy to : Solicitor General, Ministry of Justice and Constitutional Affairs
: Principal Hospital Administrator, Mulago National Referral Hospital
: Executive Director, Center for Health, Human Rights and Development [CEHURD]

Enclosure.

Vision: "To be the leading center for Health Care Services"