

From cardiothoracic surgeon to village health advocate

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Uganda's Director General of Health Services, Prof. Francis Omaswa says that abolition of user fees in his country has enabled more people to access health services. "Development partners now agree that it was a mistake to require people to pay for health services ... the rest of the world should go that way"

From high tech practice in the UK and Nairobi, Prof Omaswa established a model rural operation theatre in a poor rural area in Ngora, Eastern Uganda that became the envy of East Africa. He established model village health teams to provide the backbone of a district health system. When he became the head of Uganda's ministry of health he pushed for these teams country wide. This, together with President Museveni's open and multi sectoral approach to the HIV/AIDS epidemic, has contributed to Uganda's success story: HIV prevalence rates have plummeted from 30% to 5%.

Charles Wendo caught up with him and gives a rare glimpse into this remarkable son of Africa: surgeon, public health advocate with rare leadership skills.

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AHS: What do you specialise in?

A: I'm a cardio-thoracic surgeon. Having graduated with the first degree in medicine I undertook a Masters course in Surgery and became a general surgeon then I specialised in cardio-thoracic surgery. I did my first two courses in Makerere University at the third one in the UK, with the Royal College of Surgeons of Edinburgh.

AHS: So can say you specialise in heart surgery?

A: Surgery of the heart, blood vessels and everything inside the chest including the lungs, oesophagus and glands like the thymus. Everything inside the chest.

AHS: In which university did you teach?

A: I taught in Nairobi University in Kenya. Before that I also taught at the University of Liverpool. I also taught at Makerere University Medical School.

AHS: When you returned to Uganda, what did you do before you got to this position of Director General?

A: While I was working in the in UK the Government of Kenya sent an emissary to ask me to go and set up open heart surgery. I took a contract for three years. I was head of the cardio-thoracic unit at Kenyatta University.

After my contract, under the auspices of the Association of Surgeons of Eastern Africa, we decided to set up a service in a rural hospital. We wanted to see how good services can be set up in a rural area. We did this in Ngora Hospital. The idea was to provide cost-effective surgical services. It was quite exciting.

AHS: Were you doing heart surgery in Ngora?

A: Yes. Patients were being referred from Mulago to Ngora because there was no heart surgeon in Mulago.

AHS: How did you manage heart surgery in a rural hospital?

A: That was the point of the project - to try and work with limited resources.

What we did was to construct a low-cost theatre, equip it with limited facilities and get some staff.

Fortunately for me my wife is an anaesthetist, and we also had some clinical officers who could do some good work.

I did not have X-ray machines. I had a very basic lab but the results were very impressive.

AHS: Did you participate in setting up the heart institute in Mulago Hospital?

A: I established it. This Government came to power in 1986 and they decided that we should come to Mulago in 1987. There was no cardio-thoracic unit in Mulago. I set it up with the help of Rotary International, the Ministry of health and Makerere University.

AHS: How often did you do heart surgery in Ngora?

A: The utilisation rate of the hospital shot up more than 1000 times between my arrival and the time I left.

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There was no theatre when I arrived in Ngora. I had to build one and it is the model theatre which is being built around the country now.

AHS: Can this model work for other African countries?

A: Yes, because it is simple and efficient.

AHS: And from Mulago you were appointed Director General (DG) of health Services?

A: I was the Director of the Uganda heart Institute, then I was appointed Chief Surgeon of Uganda, and now DG.

AHS: Now that you are too busy with administration, do you miss the theatre, or does theatre miss you?

A: Certainly clinical work is more straight forward than a DG's job, and also more satisfying as you see more patients recover, but the DG's work has more impact.

I trained other people, so there is a strong team to carry out the work without me. It is the same thing I did in Nairobi.

AHS: What kind of heart surgery were you doing in Ngora?

A: Closed cardiac surgery. That is the type where you do not have to close that heart. There are many examples of this kind of operation, such as opening a heart valve, removing an infected pericardium, opening up blood vessels which are blocked due to birth defects and diverting blood from the left side of the heart to the right. I was able to do all these in Ngora.

AHS: Explain what you mean in your radio spot, 'health is made at home.'

A: It is possible for a child to be born and grow to a reasonable age without requiring hospital services. To maintain good health needs active work. It needs health-seeking behaviour. This is done at home. They include common things like feeding well, good hygiene, conducive psycho-social environment, keeping mosquitoes away, etc. If there are any threats to your health you need to understand them and avoid them.

We need to be aware of what takes away good health and how to avoid these threats, as well as how to seek whatever promoted good health.

The problem we still have is that many people attribute ill health to witchcraft or acts of God instead of attributing it to things like bacteria and risk-taking. People die in large numbers and we accept it just like that, saying God has called them. That should not be the case.

If all of us promoted good health we would not have problems. 95% of diseases especially up to a certain age are avoidable.

AHS: How do we get our people to do this?

A: We need a cultural transformation. Pursuing good health is a way of life and it comes from a state of mind. This is a message we should now start working on, using opportunities we have such as radio and newspapers. At the same time we have to work with all sections of society including traditional healers. We should get people to prioritise their health. Many of us take health for granted. We need a massive campaign.

AHS: You have been talking about village health teams. How will this work?

A: During my days in Ngora I had village health teams. I believe very strongly in it. In some countries there are people who come to ask you whether you have taken your child to school or for immunisation. One of the key weaknesses in our society is that we have not been having such arrangements.

AHS: How far have you gone with implementing village health teams?

A: We have started implementing it in 30 of the 56 districts. Within the next one or two years every LC1 zone (basis community administrative unit) will have a village health team. Their terms of service are well spelt out.

AHS: What are your achievements as the technical head of the ministry?

A: We recruited a team of good people, drew a health sector strategic plan, set out clear policies and we work well with development partners. As a result a lot of things have happened. Access to health services (people who live within 5km of a health centre) has increased from 49% to 72%. Immunisation coverage had fallen to 38% but now it is 84%. Utilisation of health services has shot up tremendously. More drugs are available now, though not yet enough. In general terms, health services have improved though we still have a long way to go. If things continue this way in 5 - 10 years we shall have a very beautiful health system. Already life expectancy is going up.

AHS: And as professor, what did you achieve?

A: I set up the Uganda Heart Institute. I pioneered and championed the establishment of the College of Surgeons

of Eastern and Central Africa. I was the founder chairman. I handed over after four years and by that time we had trained some students and I signed their certificates.

I was a pioneer of the quality of health movement in this country, with the help of USAID. I played a key role in the establishment of the Regional Centre for Quality of Health Care, based at the Makerere University Institute of Public health.

That issue of maintaining standards and pursuing excellence is the legacy I have left in the academic field.

AHS: What advice do you have for young medics?

A: They need to aim high and learn how to relate to people. Work hard and produce good quality work. It will be seen and it will be followed by money. If you just chase money without good work you will not have the money.

AHS: What's your view about the brain drain?

A: The brain drain here is a brain push. There is the question of people aspiring for better lives, so we should look at it in a more positive way. Most human beings would like to stay at home. They love their families. So if we look after them well they will not go. They only go because of the stressful conditions at home. I would like to see that suitable conditions are created so that people stay.

The populations in developing countries are growing older, so there will be high demand for young people in those countries to work. We have the young people. We should learn to produce labour for export. For example there is a high demand for nurses. Instead of complaining that developed are taking our nurses, let us train nurses for export.

In Uganda conditions were improved and doctors are not leaving at a very high rate. In the past we lost about 80 doctors annually but now it is 30.

AHS: What do you see as the main challenges for health in Africa?

A: There is so much ill health and death and people have resigned. It is not necessary that Africans live such short lives, die in large numbers and are ill so much. That can be prevented and we must know it. All leaders, including politicians and religious leaders, need to prioritise health and allocate the necessary resources. We also need better conditions

for the people who provide health care.

AHS: What lessons have you learnt from the abolition of user fees in public health facilities?

A: It has shown that we were keeping poor people away. In the rural area if you ask somebody for just sh100 (USD 0.05) he may not have it because it is not a cash-based economy. Abolition of user fees has enabled more people to access health services. Development partners now agree that it was a mistake to require poor people to pay for health services. The president should be complemented for taking that bold move against the advice of some members of the international community. The rest of the world should go that way.

AHS: You have been promising free anti-retroviral (ARV) drugs. Is this feasible?

A: We have found some money from the World Bank, Global Fund, Government of USA, GTZ and MSF. We are confident that over the next three years there is sufficient money to provide free ARVs for the people of Uganda.

We were among the first people on the continent to begin using ARVs and we have gained experience. We have been able to manage ARVs well.

The plan will be to make these drugs available at district hospitals and even clinics which meet certain criteria. Within the next few months these drugs will be made available.

AHS: Free of charge?

A: Yes.

AHS: What can the rest of Africa learn from Uganda's achievements in the fight against HIV/AIDS?

A: Uganda is a success story in being able to reduce prevalence from 30% in the highest centres to an average of 5% now. This was a result of political commitment, sound technical programmes, a high calibre of people and good use of the media. We have been open to new ideas and innovation.

AHS: Would you like to add any final comments?

A: I see myself as an African, proud to be African, and believing that every place can be as good as its people make it. It is my motivation to see good things happen in Africa.



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