

Antibiotics and drug resistance: a mother tells of her nightmare

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As a mother with little children, I have, on many occasions, woken up in the middle of the night to find that my child has a terrible cough, a high temperature, or a running stomach, and possibly vomiting.

It is a common practice for me to reach out for my stocked "home pharmacy" and self-dispense paracetamol, cold cap and/or antibiotic syrups or tablets to the child.

If the child's condition does not improve, I normally self-dispense even stronger medication, which might be rectal diclofenac for pain and fever.

It is only if the temperature, pain and uneasiness return or persist that I decide to seek professional help in a health facility.

As routine, health workers take a temperature reading, weigh the kid, and send you to the laboratory. On receipt of the laboratory results, the doctor most likely declares that there is nothing significant seen, or that the child has malaria or a bacterial infection (don't ask them which bacteria, lest they get annoyed with you). If not, they are likely to say it is a viral infections (not known).

Only a few health workers would prescribe a painkiller and ask you to monitor the child a little longer if the laboratory results are inconclusive. Majority will go ahead to prescribe a cocktail of anti-malarials, antibiotics and painkillers. They normally assure you that it is precautionary measure in case the infection or malaria was not detected or in case it was too early to detect.

As a parent who wants their child to be well, you are left with no option but to trust the doctor and pay for all the medication.

What they never tell you is the danger of administering medication without a conclusive diagnosis, especially in children.

In fact, when the child does not recover, another trip to



A mother with her children. Children are becoming ever more vulnerable as bacteria become resistant to drugs

the health facility means you will be given even stronger medication. If they are treating a bacterial infection, you may be given an intravenous ceftriaxone, and have to go back three or more times to complete the dose.

If one is lucky and the child improves, it does not take long before a school-going sibling introduces to the house another strain of infection that normally starts with a bout of flu and ends with a bad chest infection. Then you start the cycle of treatment all over again.

The more kids you have in different schools, the more respiratory viruses they bring home.

Personally, I have gained experience, and carefully take note of the medications

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that the doctor gives, what works and what doesn't work. I now have a well-stocked pharmacy at home with all these medications.

They range from ampicillin, azithromycin, cefepime, ciprofloxacin, cefuroxime, augmentin, etc. I know a family that has included ceftriaxone because they are able to give it in the vein themselves. Others keep even the last-resort antibiotics such as meropenem, because they want to knock out the germs at once with-

out going back and forth and you no longer need to spend consultation fees (some as high as Shs 50,000), laboratory fees and other fees.

It sounds convenient until you learn of the dangers of this practice. The more you use these antibiotics, the more the organisms within the home and the environment around you get used and the less effective the drugs are bound to become.

Secondly, the alternative medicines are more expensive and sometimes have bad side effects or may not be easily available at all.

The unknown danger is that the more times the child in a home or a community uses antibiotics, the more the organisms get used to those antibiotics and thus breed a

pool of resistant organisms that are able to survive that constant use.

The situation is not helped that there is no pharmacy in Uganda (NONE) where you will go and anybody refuses to sell to you antibiotics. This is besides the fact that antibiotics are restricted drugs and are only supposed to be given with a prescription from a qualified health professional.

While this is the scenario for an urban elite mother, the situation for a village mother is completely different. Theirs is a situation of sharing resources. When two children are sick, they will share whatever few capsules the mother was able to get from the local drug store. This is complemented with a few herbal concoctions. This means the organisms are getting exposed to an under-dose that can't kill them and instead encourages them to get used, survive and resist even higher doses in future. For many rural drug stores, the mother will only be asked what they want and for how much; the full dosage is not the issue. So, the mother picks a few tablets and if the situation improves, they are okay; if it gets worse, they go for a few more tablets until the situation is completely irreversible with same medicines, and sometimes may end in the worst case scenario (death).

With this kind of situation going uncontrolled on for the next five, 10, 30, or 50 years, what will happen is quite obvious: the population will be living with only resistant organisms. And, therefore, the general population will be faced with more untreatable infections.

This is the reason that the issue of antimicrobial resistance has attracted global attention and hopefully this will create more awareness among the public, the health professionals and policy-makers and trigger collective actions that may retard the development of resistance and give more alternatives to the population.

The week of November 14-20 of every year is the World Antibiotic Awareness Week. The theme for this year's awareness week is "Antibiotics: Handle with care". The week aims to increase awareness of global antibiotic resistance and to encourage best practices among the general public, health workers and policymakers to avoid further emergence and spread of antibiotic resistance. In this article we share silent nightmares of mothers with little children with resistant infections.

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