Policy dialogue

Improving Patient Safety for better Quality of Care

Kampala, Uganda
14th May 2014

Report

This report was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

This policy dialogue was informed by the following policy brief:
www.evipnet.org/sure

What is a policy dialogue?
A structured discussion focused on an evidence-based policy brief

The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?
People with relevant expertise and perspectives, including policymakers, civil society and researchers

The complete list of participants is attached as Appendix 2

What was the aim of the policy dialogue?
That discussion and careful consideration should contribute to well-informed health policy decisions

The dialogue did not aim to reach a consensus or make decisions

What is included in this report?
Views, opinions and insights of individual participants reported without attribution

The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue

These opinions may or may not be consistent with or supported by the policy brief or other evidence

It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated

Nor should it be assumed that they represent the views of the authors of this report
Key messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

- Policy and management decisions together with practice by frontline health workers have an impact on the quality and safety of health care services provided. The problems and solutions should be considered through the framework of the health system.

- Patient safety is only a subset of health care quality as a whole. Other issues such as efficiency, effectiveness of services, and patient-centeredness also impact on quality of care.

- Factors influencing patient safety include: Patients’ right to information and responsibility, medical paternalism, inadequate funding, inadequate facilities, training, ethics, inadequate human resources for health, poor motivation for health workers, medicines and supplies, appropriate advertising for health, and the regulation of all health professionals.

- Patients and consumers should be empowered to demand for good quality health care. Consumers’ health literacy needs strengthening. Most of health consumer empowerment is being undertaken by civil society, and government needs to be more involved in the process. Empowering community is very effective, it promotes ownership, and consumer confidence. There is need to foster good relations between healthcare providers and the community.

- Human resources for health issues need to be addressed. These include; inadequate numbers, skills, skill mix, poor remuneration and compensation, as well as regulation.

- Medication Review can help reduce on costs arising out of inappropriate prescribing. The Ministry of Public Service should ensure that clinical pharmacists’ posts are allocated for lower level health centres II, III, and IV. Training of alternative allied health cadres will be needed to fill this gap.

- The research evidence on incident reporting is not yet be clear for the health sector but in the aviation industry incident or error reporting has been shown to improve safety and quality of airline services. This is an intervention that could be investigated for the healthcare industry.

- Public release of performance data for health facilities is important in helping clients choose where they want to go and receive care. Grading of facilities informs patients about the quality of care expected at a particular health unit.
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Background

The Director General of the Uganda National Health Research Organisation (UNHRO), Dr Sam Okware welcomed participants to the dialogue on Patient Safety for Uganda. A number of safety incidents in our hospitals due to weak, and inefficient systems, inadequate drugs, inadequate human resources for health. There are efforts by some stakeholders to deal with these issues. The SURE project at Makerere University with stakeholders has produced a policy brief on Patient Safety which describes the state of the research in this field. There are a number of options to be considered. These include human resources for health, empowerment of consumers, and review of medications. He requested the participants to introduce themselves. He introduced the moderator, Mr Delius Asiimwe, the Executive Director of Kabano Research and Development Centre, and requested him to facilitate the proceedings. Mr Asiimwe outlined the objectives, procedures and rules of the dialogue. He invited participants to add value to the policy brief and freely share their views on the subject. Minutes for the meeting would be kept but the identity of the contributors would be kept confidential. He allowed ten minutes for participants not familiar with the documents to go over the executive summary of the policy brief report.

The problem

Patients interact with the health system and therefore we must look at this problem from the components of the health system. There are six components according to WHO. We must look at how all the six components of health system impinge on the safety of a patient. The aspect of a dilapidated infrastructure should be included because it can impinge on the safety of the patient both physically and being a source of infection. Adequate provision of utilities like water and electricity – these have an impact on the safety of a patient. Patient safety may not only be within the ward but also outside wards where there could be bush growing around the health unit, carelessly thrown materials which children often play with. Personal protective equipment both for patients and health providers should also be included in the policy brief.

As we look at the safety of patients, we should consider the safety of the healthcare providers. Today, you are a health worker, tomorrow you are a patient. What are the rights and responsibilities of patients? The responsibility of patients and their caretakers is critical.
Provider behaviour, is also critical such as that of prescribing antibiotics carelessly and irrationally.

The health system needs to be considered in its completeness. Usually blame is placed on frontline workers and those delivering services but management decisions have many implications with regard to how services are delivered by health workers. To what extent should we consider the management and all people in-charge of decision making in ensuring that health facilities function properly? For example who is going to be penalized for poor hygiene in the health centre – should it be the nurse or a hospital manager who has failed to supervise cleaners? Human resources for health includes more than just healthcare professionals but also support staff. Support staff in upcountry facilities are not being paid on time. Hence, work like cleaning grounds around facilities, toilets, is not being done.

The problem should also focus on patients rather than limiting it to health workers. The problem statement should spell out how the low level of awareness among patients about their rights as a factor that affects patient safety. Patients have low expectations from the health system. This needs to be addressed. It would be good to have sensitization at community level. Posters need to be put around health facilities educating patients how to protect themselves.

The policy brief clearly articulates the problem of patient safety as a result of the faulty health system. The definition of patient safety is only a subset of quality. Efficiency, effectiveness of services, patient-centeredness, reducing waiting times and delays all impact on quality of care. It would be too much to address all these issues affecting quality in this session. We should be more focused on addressing the issues of safety that the policy brief is addressing.

Demand creation for safety should be the starting point. There is no demand for safety. The lack of patient involvement is due to medical paternalism, because of provider-patient distance. Doctors are very poor communicators. The problem is with the training. Patients feel the providers are more knowledgeable than they are, so whatever health providers do is right. There is some literature suggesting ‘medical paternalism’ where what the doctor says goes. Patients do not have a say in healthcare that is administered them. We need a whole process of transformation of the culture of paternalism in healthcare. There is also the challenge of private insurance companies that want to govern doctors treatment practices so that they can make more profit.

Unqualified personnel, is the other thing to emphasize. Some health facilities have personnel who learned on the job and have good skills. The issue then is how to help these personnel achieve qualifications. This problem of unqualified health workers should clearly come to ensure that all health facilities have qualified personnel.

The National Drug Authority should effectively monitor adverse drug effects. Inadequate primary healthcare grants such as a health centre III getting only 450,000 UGX per quarter is really not enough. Some facilities do not have placenta pits. There should be overall promotion of cleanliness, quality and improving patient safety. We tend to quickly get driven by medication errors and forget the big picture of medical errors. There are surgical errors, medical records errors. We should be broader than this to incorporate all the other aspects of errors. How do we handle issues of confidentiality regarding safety of patients?
The evidence we use should be from within our context and the options should match the problems. The role of a nurse in a developed world is completely different. The issue of staffing cuts across all professions. There are problems with training, ethics, inadequate human resources for health, poor motivation for health workers, medicines and supplies, etc. Perhaps we could tag payment to performance.

75% to 80% of health consumers rely on herbal or traditional remedies. There are a lot of adverts and promotional activities for traditional healthcare practitioners. The medical Council does not allow medical professionals to ‘advertise’. Hence, there is no alternative voice via promotional spaces or the media for biomedical practitioners.

We should decide what is acceptable advertising and what is not. Giving appropriate information with guidance on what services are available, and where. One can provide general information about services or products available, but do not say ‘your services or your product is the best.’ The Medical Council will then hold you liable as a medical practitioner.

There are four professional councils; for doctors, midwives, pharmacists and allied health personnel. Many people think the doctors’ council is in charge of all health workers which is not true. There is now a bill in parliament looking at traditional health practitioners which will govern this sector.

If patients find out that there is risk from medical devices such as infection associated with disposable needles and syringes they could reject care. Therefore there should be a restriction on information shared with patients as this can unnecessarily expose health workers and expose the system.

Some new hospitals are poorly designed, they are using smooth tiles for the floors instead of terrazzo and patients are getting fractures.

Who are the accountable persons in healthcare delivery? Hospital spokespeople are not the accountable people and are not likely to effect change, as their job is to protect the image of the institutions they represent. Such as patients jumping from Mulago hospital to their death. Why is this happening and what has been done to prevent this?

### Policy options

**Policy Option 2: Consumer empowerment:**

Organizing consumers is important. There is success in organized treatment groups for example; HIV, Cancer, and others. Getting patients together who are affected by the same problem expands consumer voices on the issue.

Patients and consumers can be empowered through education. If patients are educated about the medication they are taking there would be fewer medication errors. They should know if they are taking the right medication.

There are some organisations routinely conducting patient satisfaction surveys. The Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau do this on an annual basis. This is a good feedback mechanism for patients to let us know how they view the system on issues like cleanliness and, lighting in facilities and other infrastructural issues.
Healthcare professionals should stop ‘playing God’ on patients. It should be acceptable to health workers for a patient to ask you if you have washed your hands before touching them. Government should put in place deliberate efforts, such as training of the village health teams.

Whereas we may be trying to address issues of patient safety within the conventional settings, we should also be mindful of the traditional health consumers. The consumer should be empowered to know what they are consuming from the market in addition to what has been prescribed, that this is free from contamination, for example harmful bacteria. The consumer should be empowered to hold whoever comes as a health provider accountable for his or her safety.

What has government done to empower communities? Most of health consumer empowerment is being undertaken by civil society. Empowering community is very effective, it promotes ownership, and consumer confidence. We recently had a dialogue with patients in Wakiso district. Patients demanded to know why the maternity unit had been closed. It turned out there was an anthill growing into the facility. The community organized and dug up the anthill and the maternity unit was able to re-open.

The biggest challenge in service delivery is creating demand at community level. Once our customers know what is expected of healthcare services and healthcare professionals, the Government will step in line. The customer is the boss. The community should be empowered to demand adequate care. If you go to some districts in Uganda, you may find only one doctor, and the community is not demanding for more health personnel. Government is aware of the human resources problem. However, it is the consumers who should drive demand.

The Uganda Medical and Dental Practitioners Council reminds practitioners of their professional responsibilities. The medical register has been upgraded and is now available on mobile phones and on the Council website. Soon images of the practitioners will be available to identify whether one’s medical practitioner is legally registered. Some of the doctors are now being asked that we don’t see you on the Council register, so we don’t want you to work on us. A few years ago registration of doctors stood at about 25%, now its 65% because patients are asking doctors whether they are registered.

There is Patients’ Charter already in place. Civil Society should use this to educate patients about their rights and obligations. Responsibilities of patients should also be emphasized just as it is with rights of patients, for example stress to utilities, caused by multiple attendants of patients. You can find communities leaving their livestock roaming around and damaging health facilities.

Much as we need to protect health consumers, we also need to protect the health system. There was an incident where community members wanted to lynch a midwife for not being able to wake up to attend a patient. Perhaps she was overwhelmed, was the only health worker available at the facility and had been working long hours without rest. If there is a lot of litigation, this could shut down entire organizations or health units leading to loss to the community, particularly for the private for profit and private not for profit health sub-sector. One law suit can make the whole health unit collapse.

The cost of doing business could go up, reducing on access to healthcare. However, suing the system also serves to protect other consumers and should be a learning opportunity.
Community empowerment may not necessarily lead to more litigation. Because this looks at what resources are available and what can be done with these human resources, materials and financial resources. So community as a result is aware and may not harbor unrealistic expectations from the district. The Uganda National Health Care Consumers organization has worked in 30 districts to educate health consumers and they have not had any litigation issues in these districts. The consumers may actually become more supportive of the facilities that serve them if they are aware of the limitations that face them. The health consumers are voters, and if they are educated, aware of the problems facing the health services they would demand that decision-makers, politicians improve health services in exchange for political support.

Politicians sometimes incite the community against the health workers. A Resident District Commissioner tried to get a doctor arrested, but this incensed the community as this was the only doctor serving in the facility. Politicians lie that they have ‘supplied drugs’ to health facilities, which is in fact not true leading to divisions between the community and the health workers serving them.

**Policy Option 1: Nurse Staffing models:**

In many health facilities, nursing responsibilities have been handed over to the relatives, for example, relatives feeding a patient through a nasogastric tube, the patient could choke and die. This is due to shortage of health professionals. You could find very many patients in the ward, all being attended by two nurses. Families are doing nursing work on the wards. This leads to a high burden of demand for facilities and utilities like water, electricity, hence very expensive for government to maintain. Already limited funding resources are then wasted which could have been used to improve the health system.

We need an appropriate staff skills mix. Even if you have enough nurses, if the other clinicians are not there the nurses will end up doing their job and services will not improve. I disagree with the contribution that there is need to consider the entire health workforce instead of nurses. When a patient is being worked on a nurse is involved and a nurse spend more time with the patient compared to other health professionals.

The issue of staffing is a very big problem and cuts across many professions. The doctors are a few, ethics are poor. Immediately after qualifying a doctor wants to marry, drive and live in a personal new house – but where will the money come from? We had the issue of task shifting which was very popular at some point in time. The doctors were task shifting their core roles to nurses so that the doctor is free to run his private clinic and the nurse also pushes tasks to the nursing aides. Instead of nurses specializing to be more effective nurses, they also want to upgrade and become doctors. Effective supervision of the human resources is required at all the levels of the healthcare system. Task shifting to lower level health cadres might lead to errors because they are not trained to perform these new tasks. In other countries like Sweden, registered nurses have PhDs, so task shifting has lost meaning.

At the national referral hospital in New Mulago there are certain departments which don’t have senior consultants because they were not provided for in the staff establishment. There is need to come up with a realistic staff establishment. We need to open up and recruit more nurses instead of having one nurse running around a ward the whole day.

There was a policy shift introducing comprehensive nursing about 15 years ago. This training for two and half years produced half-baked nurses who cannot do everything as expected.
This is where the problem originates, health workers who are not well-trained are not going provide the best care. So in this policy option, what are we saying? Are we going change and go back to the original way of training nurses which produced midwives and nurses or continuing with comprehensive nurses, which has become a problem? The Ministry now recommends that all comprehensive nurses take refresher training to sub-specialize either in midwifery or general nursing. We must really emulate the role of a nurse in the developed world. For example if you have a cardiac surgeon there must a nurse specialized in that area and if you are a specialist in diabetes, then there must be a relevant nurse for that specialty. The health training institutions need to be aware of where there is greatest demand for health cadres and train accordingly to fill the human resource gaps.

The problem is not really nurses. The health care team is diverse and all of us have professional responsibility as health workers to ensure patient safety. So if we are to go with the option targeting professionals, then it should be all inclusive. Managing a patient is team work. There is no person who is going to be fully responsible for patient safety. We should do it as a team. So, option 1, should target all the health professionals.

When we to look at professional councils, what role are they playing to ensure that their members are professionally accountable in the health care settings? So this policy option should see how to bring in professional councils to see how they also help in the supervision aspect. Already there are some efforts to form what is called district supervisory authorities, and these authorities can still forge a way to reach community levels. Peer support through the health professional associations could help embed a culture of safety with their members. There is need to improve the regulatory framework of the human resources, and address human resource shortages especially at the lower level health units because this where the majority of our population interfaces with the health system.

The Uganda medical and dental practitioners’ council has a big role to play not only on the health provider side but also in educating communities to improve policy option 2 on patient empowerment.

All the evidence on the policy options provided is from other countries but not specific to our context in Uganda. It is very important that before advancing this policy options we include more context specific evidence. Evidence used in a policy brief like this should be local because evidence from other countries may not be applicable here.

In general, we need to address the HRH levels. This is where our population first interfaces with the health system. Nurses spend a lot of time with patients more than other health cadres and emphasizing the role of nurses is important here. Few nurses on the wards means that a nurse does not get to adequately discharge her duties. Patients’ sharing mattresses, is an issue of patient safety. Toilets not being properly cleaned, is an issue of safety. If you have few nurses on the wards, it is not possible for them to provide adequate supervision.

There are issues of health financing addressing the scaling up of all the policy options.

**Policy Option 3: Medication Review:**

This is also a perfect option because medication review has been a challenge. We know when taking history of a patient many health providers do not concentrate on history of drug use.
This could help reduce on costs arising out of inappropriate prescribing. We could take an integrated approach because all the policy options are important.

We want patients to receive the best treatment but there is the problem of sub-standard devices to administer medicines. Some nasogastric tubes have no markings, some intravenous giving sets are too short and do not allow the patient to move comfortably. We need adequately trained procurement personnel for health supplies and equipment. Nurses should be confident to report devices which are not appropriate. Vitamin K is packed as 10mg, yet a newborn baby needs 1mg. So nurses have to estimate how much the correct dosage is before administering leading to patient harm.

**Potential Alternative Option: Incident/Error Reporting:**
There are limitations from the studies found on incident reporting. This may not yet be clear in the health sector but in the aviation industry incident reporting has been shown to improve safety and quality of airline services. Everything is recorded and near-misses are used as learning points for better improvement of systems. This is something that we could adopt in the healthcare industry.

The Uganda Catholic Medical Bureau tried to emphasize reporting of medical errors but we were cautioned by lawyers; the moment you start documenting incidences, if a judge knows that you have such a document they will order that you produce it in the courts of law. Incident reporting could be detrimental to health practitioners. I disagree with the idea of not documenting incidents but agree that we need to protect the health system. We should document medical errors in a way that it doesn't put the health worker at risk of reprisals. For example, health centres are doing maternal audits for internal use only to help improve the problem of maternal deaths. As a result, we now know what is happening and how to respond. If there is no documentation, we cannot do continuous quality improvement. The health system is not there to protect health workers so the issue of not recording incidents is not right. We have to abide by the health system regulations and protect the patient, because healthcare professionals are also patients benefitting from the system.

Information should be recorded and shared for what could have happened during a medical incident. If you hide mistakes under the table, it means that other health workers are going to repeat those mistakes and cause more harm to patients. Health workers should not keep quiet about errors involving patients. Incident reporting is currently only voluntary practice in some hospitals and health facilities but should be made mandatory in the entire sector. Mandatory incident reporting is for accountability purposes. However, the biggest problem is lack of understanding on how to handle patients who have been harmed.

**Potential Alternative Option: Patient Safety assessment and enforcement:**
Public release of performance data for health facilities is important in helping clients choose where they want to go and receive care. Grading of facilities informs patients about the quality of care expected at a particular health unit.

If I need an operation, I should have information where I can get good service. The highly graded hospitals or facilities can be given responsibility to supervise other health units. ‘Support Supervision’ sounds good but rather it should be inspection. If someone comes to supervise me, I can only tell them what my problems are. But if you come to inspect me I will look at standards I am supported to adhere to.
Implementation considerations

There are no clinical pharmacists posts allocated for lower level health centres II, III, and IV. Therefore training of other allied health cadres is needed to fill this gap. The Public Service should ensure that these positions are needed, right from the district to the lower level health units.

Patient safety is a product. What is the value chain? To contribute to the final product. The patients should be cured of the problem that took them to the hospital and shouldn’t encounter any encumbrance during care.

What is the role of the policymakers in health care safety? What is the role of the healthcare managers, healthcare practitioners? There should be levels of implementation where every health actor should fulfill their role.

Before the consumer interacts with the system there should be information provided for them, such as the patients’ charter. Patients’ rights should be taught together with their responsibilities.

Health training institutions should increase on intake of pharmacists to fill the gap required.

Next steps

The Assistant Commissioner for Clinical Services, Ministry of Health:

Dr Jackson Amona thanked the Director General of UNHRO, the moderator and colleagues from Makerere University, colleagues from the Ministry of Health, participants from the various institutions, guests, ladies and gentlemen. Policy dialogues such as this are very important to the Ministry of Health. This topic on patient safety is of interest to both the Ministry, patients and stakeholders. If healthcare quality is improved, then issues of safety for patients would be included. People go to traditional practitioners because of the gap in modern healthcare hence the need to examine the health system. If good care was provided within the formal health system this could compete favourably with the traditional healthcare systems. We need to look at ethics, from the people who are providing the service to those that are receiving the service. When patients are harmed, there are associated costs, patients have to stay in hospital longer to be treated, as well as costs to the patient in terms of loss of health, loss of time, loss of income. It is better all-around to provide safe and quality service delivery. It is more cost-efficient. Team work is important in providing services. The health management information system should be used to improve the quality of services at the facility level before this is sent on to the health sub-district and Ministry headquarters. The Japanese talk about the 5 S strategy; sort, set, shine, standardize, and sustain; which can be adapted to improve quality of care together with safety. We need to let patients know what their rights are. Each of us has considerable contributions to make in terms of leadership and governance in healthcare.
The Director General, Uganda National Health Research organization (UNHRO)

The human element is critical in quality and safety. We need core values such as accountability, dedication, skills, motivation, correct training and proper incentives for good work to be done. Task shifting has been turned into reverse delegation which is not good.

The policy brief will be revised and re-circulated following today’s discussions.

I thank participants from the Ministry of Health, other stakeholders, Makerere University and the authorship team for the policy brief.

‘Health is made at home and repaired in the health system.’

The meeting was adjourned at 1.50 pm.
### Appendix 1: Agenda

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<td>Registration</td>
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<td>9.00 - 9.05AM</td>
<td>Welcome by the DG, UNHRO</td>
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<td>9.05 - 9.20 AM</td>
<td>Introduction of participants and Moderator</td>
<td>Dr Sam Okware</td>
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<td>9.20 – 9.30 AM</td>
<td>Procedures and Rules of the Dialogue</td>
<td>Mr Delius Asiimwe</td>
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<td>Problem Section of the Policy Brief Discussion</td>
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<td>10.45 – 11.00 AM</td>
<td><strong>TEA/COFFEE BREAK</strong></td>
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<td>11.00 – 12.00 AM</td>
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<td>12.00 – 01.00 PM</td>
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<td>Evaluation of the policy dialogue</td>
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<td>01.15 – 01.30 PM</td>
<td>Wrap up and Way Forward</td>
<td>Asst. Commissioner, Clinical Services</td>
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<td>01.30 – 01.45 PM</td>
<td>Closing Remarks</td>
<td>Dr Sam Okware</td>
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<td>01.45 PM</td>
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Appendix 2: Participants

**Dr Jackson Amone**  
Assistant Commissioner Curative Services  
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**Dr Makumbi Issa**  
Assistant Commissioner, Epidemiology and Disease Surveillance  
Ministry of Health

**Dr Sam Okware**  
Director General  
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**Dr Katumba Ssetongo**  
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Competing interests
None known.

Acknowledgements
This policy dialogue was organised with support from the “Supporting the use of research evidence (SURE) for policy in African health systems project. SURE is funded by the European Commission’s Seventh Framework Programme (Grant agreement number 222881). The funder did not have a role in drafting, revising or approving the content of this report.

Suggested citation

SURE – Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems – is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Regional East African Community Health (REACH) Policy Initiative. SURE is funded by the European Commission’s 7th Framework Programme. www.evipnet.org/sure

The Regional East African Community Health (REACH) Policy Initiative links health researchers with policymakers and other vital research users. It supports, stimulates and harmonizes evidence-informed policymaking processes in East Africa. There are designated Country Nodes within each of the five EAC Partner States. The REACH Country Node in Uganda is hosted by the Uganda National Health Research Organisation (UNHRO). www.eac.int/health

The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available. www.evipnet.org