Policy dialogue

Improving Patient Safety for better Quality of Care

Kampala, Uganda
16th 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: Nabudere H, Asiimwe D, Semakula D. Improving patient safety for better quality of care. (SURE policy brief). Kampala, Uganda: College of Health Sciences, Makerere University, 2014

http://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.

- Health system challenges impacting on safety in care provision include; poor career guidance for health training, low health literacy among consumers, poor ethics, poor quality control, weak sector regulation particularly for private practitioners, shortage of healthworkers, poor financing, weak referral systems, decentralization, inefficient safety assessment and enforcement practices, insufficient training and weak health infrastructure.

- Potential interventions to mitigate patient harm include: community health dialogues, regulation and monitoring of health practitioners, political commitment and support, re-introduction of health visitors for health education and community mobilization, engagement, advocacy and sharing of information among stakeholders, improving on health waste management, strengthening of quality assurance, identification of resources for implementation of interventions, functional multi-sector and intra-sector coordination, public advocacy and communication.

- Government participation in consumer empowerment is imperative through health clients’ organisations, patient satisfaction surveys, informed community demand for health, and Village Health Teams (VHTs).
## Table of contents

**Contents**

- Background ........................................................... 5
- The problem ........................................................... 5
- Policy options .......................................................... 8
- Implementation considerations .................................... 11
- Next steps .............................................................. 12
- Appendix 1: Agenda .................................................. 15
- Appendix 2: Participants .......................................... 16
The views, opinions and insights 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 that informed this dialogue 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.

Background

The Director General of the Uganda National Health Research Organisation (UNHRO), Dr Sam Okware welcomed the Parliamentarians and other guests to the dialogue on patient safety for Uganda. Adverse drug events, unsafe blood transfusions, errors associated with injections and syringes all lead to patient harm. 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 is a full report and executive summary of the evidence in the brief in terms of policy options to improve the problem. 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. He explained that the dialogue is convened between stakeholders with expertise on the topic. 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 fifteen minutes for participants not familiar with the documents to go over the executive summary.

The problem

Thank you for putting together this research on this very important subject.

Our current education system is a contributor to the problem. There is lack of career guidance for medical students and as result you find students from wealthy families taking up medical training for prestige and not willing to work in rural areas like Kotido district. Education for the health sector is very competitive, urban-centred and is accessible mostly to the middle class. The challenge is how to improve identification of students who are interested in health services provision to make sure we have professionals who are ready to work anywhere. When admitting young people to medical training schools they need to be guided that this profession, however noble, does not pay very well in monetary terms.

The transfer of medical training schools from the Ministry of Health to the Ministry of Education and Sports has compounded the problem because education sector does not have facilities where trainees can have hands on practice. Infrastructure is the other challenge, a number of health facilities are lacking either in diagnostics, bed capacity, diagnostic
equipment and laboratory services. Community attitudes and practices are also a challenge. Everybody has become a doctor of himself. People self-medicate leading to complications and wastage of medicines. The loss of confidence in the health system has driven people to rely on people who have no medical training e.g. traditional healers and quacks, before they can seek care from the health system.

There is a challenge dealing with largely illiterate and unaware masses. People have the attitude that it is the government to look after my health. It is your personal responsibility to look after your health. There used to be Government Health Inspectors checking hygiene in the communities, in the households, that homes had boiled drinking water, but this is no longer happening.

Ethics are waning among health workers. There is a problem in my constituency concerning a health centre IV where patients complain that they are not sure whether government facilities are free or not. When it comes to operation of patients, unless a patient pays, he will not be attended to, and patients die. There is need for clarification on the issues of user fees, so that if patients have to pay, the amounts should be standardised and made public.

There is need to strengthen inspection and supervision, particularly the registration of private health facilities. Is it about ability to pay registration fees? Does the Ministry of Health ensure that registered facilities have trained personnel? I am in the business and I know that motivation of registration is not about provision of quality health care, rather the ability to pay for a licence.

The motivation of workers today is about pursuit for profit. That is what motivates what we call polypharmacy. The more the medicine prescribed the more the appreciation on the part of a patient that he/she is dealing with a genuine doctor. Doctors today prescribe to a patient many types of medicines to treat the same disease. That raises questions on ethical behaviour of health workers. Patient demand is driven by information technology e.g. radio, internet and television. However, through these media, ordinary people get information from unqualified people. So people visit health workers with the prejudice that they need particular medicines.

I am quite intrigued by the 15% of people who acquire HIV from unsafe blood transfusion. These are alarming figures indeed. Is the problem with the blood bank? It is the capacity of the Ministry of Health to provide oversight to healthcare, but I should say that this is sorely lacking.

Many of the problems with regard to nurses can be attributed to the transfer of training schools under the Ministry of Education and Sports. Nursing training schools are treated like any other training institutions which has undone the ethical framework that was emphasized when paramedical schools were still under the Ministry of Health. This shift to comprehensive nurse training produces nurses with inadequate skills in midwifery. That is why maternal mortality rate has gone high in this country. Nurse training schools should not have been placed under local governments. All health training institutions should have remained under central government by the Ministry of Health. The posts of health visitors have been neglected under the decentralized local governments hence the gap in addressing maternal-related and other issues at community level. This policy dialogue should recommend that medical training institutions go back under the Ministry of Health.
The problem of shortage of health workers estimated at about 30% in some districts is deceptive because the number of available health workers is inflated by support staff which gives artificial figures.

Primary health care which has been ignored at community level plays a part in ensuring patient safety. If patients visit health workers when they are unkempt, this can negatively affect their attitude toward them. The low staffing of nurses especially in rural facilities creates work overload, so they get frustrated.

If the hospital treats me and I go back to an unsafe home environment, won’t I get sick again? Most of our health issues are preventable. Investing in expensive health care may not be the most urgent solution. Let’s look at the environment, hygiene, nutrition. Most households in my constituency have only one meal a day. Who is financing our health sector? We should invest in our own health. How do we expect donors to pay our health workers?

Weak referral systems are a big problem affecting patient safety. Although some health centres have ambulances, they do not have fuel to transport patients. If possible the policy brief should include a recommendation that there should be community support to the referral system. When fuel for the ambulance is not there a patient’s life is in danger.

What about the safety of care takers especially for patients admitted in hospitals? Recently in Obongi, West Nile in just three days’ time there was an admission of 43 patients, with an additional 40 people in the facility as carers.

The Government is aware of the inadequacy of the human resources for health. You will find that patients’ families are doing nursing work on the wards. This leads to a high demand for service utilities like water, electricity, and hence very expensive for government to maintain. This is a good example of how funding resources are wasted which could be used to improve the health system.

There are many private clinics, some licensed by the regulatory authority and some by the local governments alone. Local governments are more motivated by taxes from the private practices rather than provision of quality health services. Many private clinics do not employ trained health workers and you will find that they provide unsafe prescriptions. Polypharmacy is rampant fueled by pursuit for profit and rhymes with the psyche of the population – which believes that the more drugs prescribed, the better for the patient.

Adequate supervision of the private health sector is needed because the majority of health consumers attend these facilities. In my district, Lyantonde, a health worker was locked up and only saved by the intervention of the Minister. The communities need to be sensitized because if they are not aware of what services to expect from health workers they will demand services that health workers are not able to give.

Decentralization of the provision of health services has created more challenges. Some districts have hospitals which are non-functional or dysfunctional while some new districts do not have hospitals. That is why Mulago National referral hospital receives many patients from the districts and yet these patients do not come with money from their districts. With its limited budget, Mulago hospital does not have the capacity to provide quality care to all the patients attending there. Therefore, there should be new mechanisms where district funding caters for patients seeking care at the national referral hospital. For example, if a patient comes from Masaka district to Mulago for treatment, the national referral hospital should invoice Masaka district. There should be economic innovations in the way services are
managed by health facilities; for example, patients should not be transported many miles to Mulago hospital because the referring hospital has run out oxygen. Oxygen could even be transported to a needy hospital on boda-boda.

I defer from the suggestion that money should follow patients from one hospital to another. My opinion is that we equip all health centres, then there will be no need of moving patients from other hospitals to flood Mulago hospital.

From our point of view as the Medicine and Health Services Delivery Monitoring Unit, one of the things that we push for is looking at policies around service delivery issues. For example if a health worker steals medicines and they are given a fine of 200,000 UGX when the drugs stolen were around 10 million UGX. When somebody commits a crime and they are given community service to go and sweep, which anyway when they go out there they get a community member to do the sweeping. How do we deal with some of these things? The medical legal element needs reforms i.e. revision of punishments to deal with theft of drugs by health workers.

We should put in place community health dialogues. At community level we should reawaken that ‘health is made at home, and only repaired in the hospitals’. We should also identify potential health providers at the community level who can return to serve their communities. Community health dialogues can address issues such as male involvement, self-medication and delay to seek health care. Community health workers who are poorly paid should be subsided by the national health insurance schemes.

Sometimes it may not be shortage of staff but lack of appropriate monitoring and supervision of the health system. Regarding the Medicine and Health Services Delivery Monitoring Unit (MHSDMU), this kind of duplication by government causes a lot of trouble. There was a department which was for inspection of health care throughout the country. Now you have got another unit (MHSDMU) with much higher salary scales and different power centres. This unit is resented in the health sector. As Parliamentarians on the Committee on Health we don’t get any interaction with this unit, so that we could inform them of views arising out of the community. MHSDMU is too small a unit to do what the Inspectorate Department at the Ministry of Health would have done. This unit does not have the capacity to attend issues affecting all the health facilities in the Country. When MHSDMU leaves a health facility the situation goes back to business as usual. That means we need a functional and effective health system such that at every level i.e. at district level, the District Health Officer should effectively play their role. MHSDMU reports directly to the President and no other government department can superintend on it.

Policy options

The issues in the document are indivisible. The options should be structured in a matrix format re-short term, medium term and long term, with responsibilities for action by various stakeholders. We should tag recommendations to time lines by the responsible agencies and stakeholders.
**Policy Option 2: Consumer empowerment:**

Organizing consumers is very important. There is success in organized treatment groups, for example; HIV, Cancer, etc. Getting patients together who are affected by the same problem expands consumer voices on the issue. There is need to educate patients and consumers about their care, especially about the medication they are taking. This will lead to fewer medication errors.

There are some organisations routinely conducting patient satisfaction surveys. The Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau both do this on an annual basis. This is a good feedback mechanism for patients to let us know how the view the system. e.g., issues concerning care that is provided, infrastructure, and lighting among others.

There is no one going to make this option more effective than the consumers themselves. When you empower communities they can hold their leaders accountable. We should all look at community empowerment as a value that we can pursue. Involving community in patient safety will put their leaders and service providers to task. 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.

What is the role of government in empowering communities? Most of the health consumer empowerment is being undertaken by civil society. Empowering community is very effective, it promotes ownership and consumer confidence.

We held 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 the healthcare services, the healthcare professionals and the Government will step in line. The customer is the boss. The community should be empowered to demand adequate care.

Village Health Teams (VHTs) should be commended as regards empowerment of communities. Where there are VHTs, you notice a difference in terms of information dissemination to communities and guidance. I would recommend that VHTs be empowered through more training to enhance their work. In Ngora constituency about 60% of expecting mothers used to go to traditional birth attendants for antenatal and other related services, but because of the work of VHTs almost all mothers are now using the health centres. As Members of Parliament I want to emphasize that we advocate for capacity building of VHTs because much as they are volunteers they are very committed to their work.

I am wondering why members of this policy dialogue are giving more praises to VHTs than the health system who are paid and facilitated. This follows that there is a need for a strong and effective national health system.

The Uganda Dental and Medical Practitioners Council serves to remind practitioners of their professional responsibilities. The medical register has been upgraded and is now available on mobile phones. Soon images of the practitioners will be available to identify that one’s medical practitioner is legally registered. The Patients’ Charter is also in place. Civil Society should use this to educate patients about their rights and responsibilities.
We need to protect the system. If there is a lot of litigation, this could shut down entire organisations or health units leading to loss to the community. The cost of doing business could go up, reducing on access to healthcare.

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. Our consumer organization has worked in 30 districts to educate health consumers and they have not been any litigation cases in those 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 were educated, aware of the problems facing the health services they would demand the decision-makers, politicians to improve these in exchange for political support.

However, suing the system also serves to protect other consumers, and should be a learning point for the system.

The health system is not there to protect health workers. We have to abide by the health system regulations and protect the patient, because healthcare professionals are also patients benefitting from the system.

Politicians sometimes incite the community against the health workers. One 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’ and other resources 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:**
Nursing responsibilities have been handed over to the relatives of patients, for example, feeding a patient through the nasogastric tubes. Patients could choke and die. Effective supervision of the human resources at all the levels of the healthcare system is required. Task shifting to lower level health cadres might lead to errors because they are not trained to perform these new tasks.

There are issues concerning the education preparation of nurses. Approximately 15 years ago, training for nurses was changed with the introduction of comprehensive nursing. Many of the comprehensive nurses are poorly trained which could harm patients. This has become a problem for our health system. The Ministry of Health now advises that all comprehensive nurses should undertake refresher training and sub-specialize in either midwifery or general nursing.

All health workers have responsibility for patients to be safe. This is team work. There is no one health cadre who are fully responsible for the dysfunction of the health system. This policy option should be inclusive of all health cadres.

This evidence is from high income countries and not specific to our context here. How does this apply to our context here? We need more context-specific evidence.
Nurses spend a lot of time with patients more than other health cadres and emphasizing the role of nurses is important here. There are few nurses on the wards which 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 supervise efficiently.

In general, we need to address the level of human resources. The population interfaces with the health system through health workers. Health training institutions should be aware of where there is greatest demand for health cadres and train accordingly.

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

**Policy Option 3: Medication Review:**
There is need for peer support through the health professional associations to embed a culture of safety with health practitioners.

We all want patients to receive the best treatment. However as practitioners we are getting sub-standard devices; nasogastric tubes have no markings, intravenous sets are too short such that a patient cannot move in bed. We need adequately trained procurement personnel for health supplies and equipment. Nurses should be confident to report devices which are inappropriate. 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. Appropriate packaging could help reduce on the costs and harm to the patients.

### 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 instituted, right from the district to the lower level health units. Health training institutions should increase on the intake of pharmacists.

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

What is the role of the policymakers in health care safety? What is the role of the healthcare managers, healthcare practitioners. Could we have levels of implementation? Every level should play their role.

We should bring in the issue of information. Private practitioners, there are some basic things they do. Before the consumer interacts with the system there should be information for them as embodied by the Patients’ charter.

There is need to emphasize to patients their responsibilities as well as their rights. We need other ways of engaging community to participate in improving the healthcare system, such as organizing to clean health centres, maintaining compounds for facilities, cleaning services, etc.
Continuous quality improvement requires audit of health performance. There is need to record and document healthcare delivery. Continuous professional education is necessary for all health workers.

Next steps

Director General, the Uganda National Health Research Organisation:

Honourable Members of Parliament, friends, ladies and gentlemen and other participants, I thank you for your participation. I would like to thank you for your comments: points of emphasis, points of agreement which indeed have enriched our discussion and our policy options. I have learnt about four major issues which have been of concern to all of us:

- The first one is that of training, because training of medical workers has changed over the last 10 years to appoint where we fill that there is some uncertainty. Health training is a calling, selfless and it is that you do from the basis of your heart. Competition has eliminated some of the poor students – favoring those from rich families. The shift of training from Ministry of Health to Ministry of Education and Sports has also to some extent compromised standards basically because now, students are trained like everybody else – having long holidays and no night duty etc. The issue of mentorship has become very difficult and also a very rare commodity.

- The second issue that was of concern to all of us was that of enforcement ethics, reinvigoration of ethics and inspection which now taken a back seat. There is a need to review mass registration of clinics and drug outlets.

- There was the issue of core values which are very rare these days; issues of accountability; issues of commitment, issues of skills. All these have come up as issues affecting our health system. It is important that these are taken care of through mentoring and continuing medical education. Finally, there is the issue of human resource which is really a very big problem: scarcity and their motivation especially the scarcity of the midwife and health visitors who were in-charge of motivating community-based interventions. We all recognised the need for teams among all health cardres both specialized and non-specialised cardres. The post of health visitor should be reintroduced. Members were concerned about the issue of task-shifting as reverse delegation. Continuing medical education has been emphasized.

- It also came out clearly that prevention is the focus. There is complacency and people are unaware what they should do for themselves yet we all know that health is made at home. Therefore the position of the health visitor should be reintroduced to help with education and community mobilization.

As a way forward, members have suggested that engagement, advocacy and sharing of information among stakeholders should continue. From here, we hope that we can be able to revise the policy brief and re-circulate it and look forward to passing to policy formulators so that it is included in the next health sector strategic and investment plan.
The Commissioner for Clinical Services, Ministry of Health:

Honourable Members of Parliament, facilitators, invited guests, ladies and gentlemen; my task is to invite the Honorable Shadow Minister for Health to make closing remarks. But before that, let me point out two things:

- Safety is of increasing impotence to everybody. If you don't have a healthy worker force then a patient who comes will not receive better services.
- There is need to emphasize the reduction of transmission of diseases. We have taken steps as a Ministry including changing to new devices, improving on health waste management and also restriction on some practices which are harmful to the patients. I am sure this dialogue will go a long way for improvements. The Ministry is committed to improving patient safety in its planning processes and implementation strategies.

I would like to take this opportunity to invite Hon Dr Lulume Bayiga to come and give remarks and officially close this meeting.

The Shadow Minister for Health, Parliament of Uganda:

Organizers of this dialogue, colleagues - Members of Parliament, participants, ladies and gentlemen. Let me first of all thank the organizers of this event. It has been a very successful dialogue because it has been multidisciplinary. One of the characteristics of policy making is that it must be a multidisciplinary dimension which can bring together ideas that are crosscutting from different individual disciplines that analyse the problem which is at hand.

In today’s dialogue I have witnessed deepening of the problem identified. Problem identification is an important part in policy making and the problem must be deeply analysed. Although this problem was analysed for us, our interaction has shown the strong depth at which problem analysis has been made. The various components that have added by various submitters today are evidence to that. I would like to share in the final product because I believe Dr Sam Okware has done a great job in taking notes.

You can also see that we have widened the search for options and the analysis of the various options and therefore the solutions that we need. As Members of Parliament, you may know that we are not policy makers but we can advise on policy on the basis of information that we get from the people that we represent from our constituencies.

Policy adoption is done by government and I believe Members here especially in the ruling NRM government can advise the Minister accordingly as I also do the same in parliament. Some of the factors that impede policy implementation must be thought about at the onset so that they are also addressed when policy is being made. The first one is about the philosophy on which the policy is being made – having the actor to understand the intricacies of the policy, engaging government to commit itself in the implementation of the policy. Commitment carries with it identification of resources for that implementation to take place. Coordination with various actors is very important and I hope in these documents the various actors must be identified and coordination mechanisms be documented. Lastly, the cooperation of the actors for whom the policy is to be made is critical.

In this policy dialogue, there are outputs that Dr Okware has read for us but permit me to say that certain other things need to be included to enable our health care delivery system deliver better:

- Can we name and shame our bad health workers? We should name and even shame health facilities that do not stick to treatment guidelines or do unethical things. The Unit
headed by Doctor Diana has tried to help in this but it would be better if the unit was within the health system. Our population is becoming more litigant as we are getting more people trained in legal disciplines, they will be looking for business I am sure they will take many of our health workers to the Courts of Law.

- I want to emphasize strengthening of quality assurance. We believe the funds allocated for quality assurance are little because we have been assessing this regularly. This country is big and the enormity of the problem need not be over emphasised. So there must synergy of actors that are doing quality assurance, partly to engage government to provide more resources for quality assurance and to enable the grassroots actors especially the Village Health Teams to perform their functions better, and also to engage leaders at various levels of administration from LC 1, LC III to engage directly in monitoring health care delivery. As well as to address issues that the population may raise especially if they are informed about the various offices where they can register their complaints so that these can be addressed.

- The last thing is about advocacy and communication. When we have a policy if you don’t publish it all the energy that was put in it will be in vain. So you need to disseminate policies and ensure that communication is effective because they are not meant only for the public but also for the various actors including the implementers of the health care delivery system. The use of this policy documents is about communicating their importance and enabling parliament to make laws that enable implementation of those policies. The various actors in the implementation of policies and enacted laws also need to be sensitised so that even a policeman in rural Uganda knows about those policies which govern the health care system so that they are not oblivious of people’s complaints.

Thank you ladies and gentlemen. I officially pronounce this dialogue closed.

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Organizer</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30 – 9.00 AM</td>
<td>Registration</td>
<td>SURE Secretariat</td>
</tr>
<tr>
<td>9.00 - 9.05AM</td>
<td>Welcome by the DG, UNHRO</td>
<td>Dr Sam Okware</td>
</tr>
<tr>
<td>9.05 - 9.20 AM</td>
<td>Introduction of participants and Moderator</td>
<td>Dr Sam Okware</td>
</tr>
<tr>
<td>9.20 – 9.30 AM</td>
<td>Procedures and Rules of the Dialogue</td>
<td>Mr Delius Asiimwe</td>
</tr>
<tr>
<td>9.30 – 10.45 AM</td>
<td>Problem Section of the Policy Brief Discussion</td>
<td></td>
</tr>
<tr>
<td><strong>10.45 – 11.00 AM</strong></td>
<td>TEA/COFFEE BREAK</td>
<td></td>
</tr>
<tr>
<td>11.00 – 12.00 AM</td>
<td>Policy Options Section of the Policy Brief Discussion</td>
<td></td>
</tr>
<tr>
<td>12.00 – 01.00 PM</td>
<td>Implementation Section of the Policy Brief Discussion</td>
<td></td>
</tr>
<tr>
<td>01.00 – 01.15 PM</td>
<td>Evaluation of the policy dialogue</td>
<td>Dr Harriet Nabudere</td>
</tr>
<tr>
<td>01.15 – 01.30 PM</td>
<td>Wrap up and Way Forward</td>
<td>Commissioner, Clinical Services Dr Jacinto Amandua</td>
</tr>
<tr>
<td>01.30 – 01.45 PM</td>
<td>Closing Remarks</td>
<td>Dr Sam Okware</td>
</tr>
<tr>
<td><strong>01.45 PM</strong></td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Departure</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Participants

**Hon. Katwesigye Oliver Kyekyenga**
Member of Parliament for Buhweju District
Parliament of Uganda

**Hon. Bagoole John**
Member of Parliament
Parliament of Uganda

**Hon. Ayoo Tonny**
Member of Parliament
Parliament of Uganda

**Hon. Namara Grace**
Member of Parliament
Parliament of Uganda

**Hon. Dr. Twa-Twa Jeremiah**
Member of Parliament
Parliament of Uganda

**Hon. Mariam Nalubega**
Member of Parliament
Parliament of Uganda

**Hon. Auru Anne**
Member of Parliament
Parliament of Uganda

**Hon. Kitatta Aboud**
Member of Parliament
Parliament of Uganda

**Hon. Kamateeka Jovah**
Member of Parliament
Parliament of Uganda

**Hon. Amongin Jacqueline**
Member of Parliament
Parliament of Uganda

**Hon. Dr Bayiga Michael Lulume**
Member of Parliament
Parliament of Uganda

**Hon. Okeyoh Peter**
Member of Parliament
Parliament of Uganda

**Hon. Kasamba Mathias**  
Member of Parliament  
Parliament of Uganda

**Ms Nakigudde Prossy**  
Assistant Coordinator NAWMP  
Parliament of Uganda

**Dr Gloria Seruwagi**  
Deputy Director  
Medicines and Health Services Delivery Monitoring Unit

**Ms Catherine Mwesigwa**  
Deputy Editor  
New Vision Publications

**Ms. Mary Kansiime**  
Photo Journalist  
New Vision Publications

**Ms. Carol Kasujja**  
Investigative Writer  
New Vision Publications

**Sister Nabukalu Rahidah**  
Principal Nursing Officer  
Kibuli Muslim Hospital

**Dr. Amandua Jacinto**  
Commissioner Clinical Services  
Ministry of Health

**Dr. Okware Sam**  
Director General  
Uganda National Health Research Organization (UNHRO)

**Ms. Mable Kukunda**  
Advocacy and Network coordinator  
Uganda National Health Users/Consumers Organization (UNHRCO)

**Dr James Mwesigwa**  
Director  
Patient Safety Improvement in Africa

**Dr Daniel Semakula**  
Researcher  
Makerere University College of Health Sciences (MUCHS)
Ms. Allen Nsangi  
Researcher  
Makerere University College of Health Sciences (MUCHS)

Mr Delius Asiimwe  
Executive Director  
Kabano Research and Development Centre (KRDC)

Dr. Harriet Nabudere  
Project Coordinator  
College of Health Services, Makerere University

Dr. Rhona Mijumbi  
Project Officer  
Supporting Use of Research Evidence for Policy (SURE Project)

Mr. Robert Apunyo  
Programs Manager  
Kabano Research and Development Centre
Authors
Harriet Nabudere, MBChB, MPH
Delius Asiimwe, BA, MA
Daniel Semakula, MBChB, MPH

Regional East African Community Health (REACH) Policy Initiative, Uganda and
Supporting the Use of Research Evidence (SURE) for policy in African Health Systems Project, College of Health Sciences, Makerere University, Kampala, Uganda

Address for correspondence
Dr Harriet Nabudere
SURE Project Coordinator
College of Health Sciences, Makerere University
P.O. Box 7072, Kampala
Kampala, Uganda
Email: hnabudere@gmail.com

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