Makerere University
COLLEGE OF HEALTH SCIENCES

Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems
The Regional East African Community Health (REACH) Policy Initiative Uganda Country Office

Policy dialogue report on national framework for sustainability of health knowledge translation initiatives in Uganda

Kabira Country Club
Kampala, Uganda.

Wednesday, 24th April 2014

REPORT

College Of Health Sciences
P.O. Box 7072 Kampala, Uganda
Tel: 256 414 530020/1, Fax: 256 414 532204
E-mail: principal@med.mak.ac.ug
Kampala, Uganda
INTRODUCTION

This dialogue was hosted by the SURE project at Kabira Country Club, Kampala on the 24th of April 2014. The SURE project produced an evidence brief which summarized the best available evidence regarding the problem, policy options and implementation considerations for sustainability for health knowledge translation initiatives in Uganda. The policy brief included the description of the health system problem, the viable options for addressing this problem and the strategies for implementing these options.

The dialogue involved participants from different organizations like The World Health Organization, Ministry of Health, Parliament, and Academia. The participants were of different professions like economists, sociologists, physicians, policy analysts and planners. The objectives of this dialogue included reviewing of the brief and working a way forward i.e. is this something we can take to a different level?

PARTICIPANTS’ UNDERSTANDING OF KT

A participant made an observation that KT concept was new to many participants of the policy dialogue and as such she requested for a brief background on the essence of KT. It was explained that KT is a process of taking research findings and incorporation into policy. For instance if a study in Rakai district in Uganda has found that 60% circumcised are free from HIV infection, such research evidence is not useful until has come to MoH and translated into a policy brief which is then shared among MoH and other stakeholders including cabinet for adoption into policy and subsequent adoption of such research evidence into the strategic plan of MOH for implementation. So KT is a process of ensuring research evidence is scientifically and systematically incorporated into a strategic plan of e.g. the MoH.

Another participant held the view that knowledge translation is not only about research, but all health information. Another participant remarked that KT is not limited to research evidence but all health information.

Another participant observed that quite often KT has been limited to mean application research evidence into policy and also comment talked about in terms of policy briefs. KT should be extended to involve practical actions of giving people information i.e on how to do effective hand washing with soap. KT should not only be looked at in terms of policy briefs.
When you talk of KT, you are talking about evidence based information. This subscribes to the school of thought that any information used must have been objective. The easiest way to guarantee that information is objective is when such information or research evidence is published (journal articles, text books etc).

Am very excited about the KT idea because this is where we have a serious weakness. Despite a lot of health research being done but this research does not informs policy and practices to levels that are noticeable. This creates a need for an office or unit to coordinate health research and provide a platform for interaction of researchers and policy makers.

**PROBLEM AND SIZE**

Writers have identified that there is a gap between researchers, policy makers and practitioners. What evidence is there to show that policy makers are not using research evidence to design policies? The policy brief should capture that evidence. Some of the reasons why policy makers may not consider certain research evidence include: for the case of safe male circumcision as a strategy for HIV prevention, there is a fear by policy makers that they could be blamed for universally implementing a policy if adverse effects occur; lack of resources (financial and human) for implementation. Research evidence could be available but to translate it into policies can be constrained of effects on the population, by fear by some policy makers and implementers. So certain policy makers tend to sit back because they do not want to be blamed in case implementation of certain research evidence leads to some adverse negative effects on the population.

There is need to highlight whether not using KT is a big problem in Uganda. Provide a case study showing that where KT has been used, it has been advantageous and vice-versa. This will define the size of the problem.

In the problem section provide a stock taking of knowledge translation initiatives in Uganda and sustainable issues of those KT initiatives. For example if a KT initiative is reliant on donor funded say for three years, what happens to it when donor funding winds up? The stock taking should consider things like governance structure, financing mechanisms and scope of work of existing KT initiatives, in Uganda. This would guide in coming up with a model which could work in Uganda. For example could be having a stand-alone KT unit or a desk officer at the MoH. The choice of a model could be informed by mapping of what is currently in Uganda,
rather than duplicating initiatives from other countries. It will be important to carefully weigh the pros and cons of stand-alone KT units in particular considering administration costs involved. The key focus will be to create demand for use of research evidence. Mapping should also be done on how some health based policies have benefit from KT, for example the Palliative Care Policy whose making was informed by the SURE project policy brief. Mapping should be continuous to track changes that result from policy interventions based on research evidence.

There is need to close the gap between researchers and community or beneficiaries of research findings, right from the inception of research undertakings. This would minimise existing mistrust about research findings by community. For example in case of Safe Male Circumcision, local people should have been engaged in the research process to ensure ownership of the generated evidence. As a result communities would be more willing to adhere to a policy intervention resulting from research evidence which was generated with their involvement. One outcome mapping would development of a guide book for researchers on how to influence policy makers.

**CAUSE OF THE PROBLEM**

A disconnect between researchers and policy makers is caused by researchers who single handily set their own research agenda in total disregard of the policy makers especially at the MoH. Researchers need to consult with MoH right from the design of research projects to ensure uptake of research evidence.

According to a participant, lack of a framework for KT **should not** be taken as one of the causes of the problem because a framework is inclusive of everything: i.e. a framework would provide for issues regarding funding and institutionalization etc. If you don’t have a framework, you can’t do advocacy because you will have a conceptualization of what you are going to advocate for.

**POLICY OPTIONS**

It was noted that there is no need to establish a KT unit in the MoH because that would be a huge undertaking. Instead it was proposed that a KT desk would be established under the policy analysis unit because this is the unit which interfaces with parliament and links MoH to other decision makers. In the beginning there would be a desk KT person under the policy analysis unit with external support/donor support for at least the first three years and later this officer (desk office would be taken up by central government). This desk officer would interface with the policy analysts and planners and create linkages with health researchers.
Two participants were of the view that because all the three policy options are essential of building a sustainable KT, it is unrealistic to implement an option in the absence of the other two. In the context of districts it was noted that if districts cannot even utilize the little information they collect, it is not realistic to think that district official have the capacity to utilize research evidence from third parties. This shows the need to address all the gaps in the three policy options with particular focus on advocacy. “We need to build the culture of research evidence demand right from the grassroots, districts and national level”. A participant suggested that the three policy options could be treated as components and under each component there could several policy options. For example under advocacy, one of the opotions would be use of champions.

Another participant was of the view that priority be given to the Policy Options 1 and 2: Institutionalization and advocacy respectively. I agree with the idea of strengthening the existing mechanism like policy analysis units at the MoH and UNHRO. It was then suggested that UNHRO comes up with guidelines to address issues of timeliness of utilization of research findings, like intellectual property rights (IPR) to ensure that research findings are timely used. Sometimes dissemination and uptake of research evidence may be delayed because IPR issues. There should be a clear mechanism on how different stakeholders can benefit from research undertakings. A KT unit would not be a clearing house of health research evidence but also ensure coordination of KT initiatives in the country. UNHRO is best placed provide guidance in health research. With regards to institutionalization policy option, there is value in looking at available mechanisms and strengthen such mechanisms that are evident in Ethiopia and USA.

Another participant prioritized Capacity building of existing personnel ahead of institutionalization because MoH already has human resource gaps, with no plan of addressing the problem in the near future. To think that a new institution can be established for KT may remain wishful thinking due to lack of internal capacity to provide sustainable resources for longer term spans.

A participant asked: how can we benefit from KT when there is no information at community and district levels? He then suggested that Policy option 1 “advocacy” needs to be explicitly presented to improve the current simple general text on advocacy.

Its only researchers who know about health evidence and what it does... That shows the importance of advocacy. Unless we market KT scientists will continue doing research for the shelves rather than informing health policy.
On institutionalisation policy option; it was suggested that UNHRO identifies and develops collaborations with organizations like World Health Organization (WHO) which use health research evidence for informed decision making. Because WHO regularly interfaces with MoH and related agencies, it can be used as an venue for information dissemination.

IMPLEMENTATION CONSIDERATIONS

To enrich these implementation considerations, there is need to incorporate good practices that have been used in other countries (USA) with knowledge translation initiatives. For example USA has a centralised system for KT under Institute for health.

Build and strengthen partnerships between policy makers and researchers to ensure uptake of research evidence by policy makers. Researchers should engage policy makers throughout the research processes. When researchers exclusively define the problem and conduct their research sometimes they generate findings which cannot be taken up by policy makers.

Access to available health information and research evidence is very difficult. At districts there is Health Information Management Systems (HIMS) which captures a wide range of information including maternal health and child health, HIV/AIDS etc.

Simplify the terminology of KT as in this policy brief to benefit wider readership. This participant proposed that KT should be presented simply as translation of research evidence and health information into health policy. Simplification of the terminology used would avoid misrepresentation issues by for example the media.

A participant suggested that a Champion (s) with good networks and connections be used to spear head process of building sustainable KT base. The Champion must be well versed with the health sector. People like Dr Kiyonga has a lot of clout in government because he can access any level of power in the country in addition to being very knowledge and experienced in health research. Another participant supported the idea of a champion adding that a number of champions could used to ensure a mix of skills and competences. The champions would be given a model that can work, to sell to stakeholders.

However, some participants disagreed with the idea of champions. It is better to establish and supporting, an office or institutional framework instead of focusing on an individual worse still who may a politician prone to be dropped from the political office.
A participant observed that, to sustain KT, government should provide in the national budget money for health research for donors can complement on.
Annex II

List of Participants

1. Dr. Okware Sam  
Director General  
Uganda National Health Research Organization (UNHRO)  
P.O Box 463 Entebbe  
MOBILE NUMBER: +256 772 409 810  
EMAIL: okwares@gmail.com

2. Mr Charles Tuhaise  
Principal Research Officer  
Parliament of Uganda  
P.O.Box 7178, Kampala, Uganda  
TELEPHONE (OFFICE): 0414377254  
MOBILE NUMBER: 0772460278  
EMAIL: ctuhaise@parliament.go.ug

3. Ms Kaitiritimba K. Robinah  
Executive Director  
Uganda National Health Users/Consumers Organization (UNHRCO)  
Plot 91 Bukoto Street, Kamwokya Kampala  
TELEPHONE (OFFICE): 0414532123  
MOBILE NUMBER: 0772638451  
EMAIL: rkitungi@yahoo.com

4. Dr Alison A Kinengere  
Librarian  
Makerere University College of Health Sciences (MUCHS)  
P.O. Box 7072, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0752634400 / 0772634400  
EMAIL: Alison@chs.mak.ac.ug

5. Christine Rebecca Mubiru  
Principal Policy Analyst  
Ministry of Health  
P.O. Box 14299, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0712 974 587  
EMAIL: crmubiru@hotmail.com

6. Ms Celia Nalwadda  
Research Officer  
Uganda National Academy of Sciences (UNAS)  
Block A4 Lincoln House Makerere University Main Campass, Kampala, Uganda  
TELEPHONE (OFFICE): 0414533044  
MOBILE NUMBER: 0702537830  
EMAIL: celianalwadda@unas.or.ug

7. Mr James Mugisha  
Senior Health Planner  
Ministry of Health  
P.O. Box 7272, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0772517281 / 0706517281  
EMAIL: mugishajab@yahoo.co.uk
8. **Ms Margaret Nakakaawa**  
Health Economist  
Ministry of Health  
P.O. Box 7272, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0756605055  
EMAIL: mnakakaawa@gmail.com

9. **Angella Muhumuza**  
Economist  
Ministry of Health  
P.O. Box 7272, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0793090249  
EMAIL: angellamarybeth@gmail.com

10. **Mr Mugisha William**  
Principal Blood Donor Coordinator / National Health Information Desk Officer  
Ministry of Health  
P.O. Box 1772, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0772464167  
EMAIL: wlmugisha@yahoo.co.uk

11. **Mr Walimbwa Aliyi**  
Senior Health Planner  
Ministry of Health  
P.O. Box 7272 Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0702447241  
EMAIL: aliyi2001@yahoo.com

12. **Mr Eric Kakoole**  
Principal Policy Analyst  
Ministry of Health  
P.O. Box 7272, Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0718022115  
EMAIL: ekarkeric24@yahoo.com

13. **Dr Grace Kabaniha**  
Health Economist  
World Health Organization (WHO)  
Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0772517486  
EMAIL:

14. **Deborah Kasule**  
Head Science and Technology outreach and Information Management Unit  
Uganda National Council for Science and Technology (UNCST)  
Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER:  
EMAIL:

15. **Mr Innocent B Mugume**  
Student
International Health Sciences University  
P.O. Box 7782, Kampala, Uganda  
TELEPHONE (OFFICE): 0312307400  
MOBILE NUMBER: 0712691565  
EMAIL: muginno@gmail.com

16. John H. Agaba  
Health Journalist  
New Vision Publications  
Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER:  
EMAIL:

17. Mr Francis Bwire Ngegemi  
Quality Assurance/Environmental Officer  
International Hospital Kampala  
P.O. Box 8177, Kampala, Uganda  
TELEPHONE (OFFICE): 0312200400/607  
MOBILE NUMBER: 0774716878  
EMAIL: francisbwire@yahoo.com

18. Dr Daniel Semakula  
Research Officer  
Makerere University College of Health (MUCHS)  
P.O Box 7072 Kampala, Uganda  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0716543000  
EMAIL: semakuladaniel@gmail.com

19.  
20. Ms Allen Nsangi  
Researcher  
Makerere University College of Health Sciences (MUCHS)  
P.O Box 7072 Kampala, Uganda  
TELEPHONE (OFFICE): 0312109456  
MOBILE NUMBER: 0773333629  
EMAIL: nsallen2000@yahoo.com

21. Mr Muyomba Dickson  
IT Officer  
Makerere University College of Health (MUCHS)  
P.O Box 7072 Kampala  
TELEPHONE (OFFICE):  
MOBILE NUMBER: 0774130458  
EMAIL: dmuyomba@chs.mak.ac.ug

22. Dr David Kaawa Mafigiri  
Senior Lecturer  
Makerere University, School of Social Sciences, Department of SWSA  
P.O Box 7072 Kampala, Uganda  
TELEPHONE (OFFICE): 0414533531  
MOBILE NUMBER: 0793371781  
EMAIL: dmk28@case.edu

23. Ms Derah Ajambo  
Research Officer  
Parliament of Uganda  
P.O. Box 7178, Kampala, Uganda  
TELEPHONE (OFFICE): 0414377254  
MOBILE NUMBER: 0775434546  
EMAIL: ajambo@parliament.go.ug
24. Mr Delius Asiimwe  
Executive Director  
Kabano Research and Development Centre (KRDC)  
PLOT 487 Kyengera, Masanda Zone  
P.O Box 35906 Kampala  
MOBILE NUMBER: 0772496036  
EMAIL: delius.asiimwe@gmail.com  

SURE Secretariat  

25. Dr. Harriet Nabudere  
Project Coordinator  
College of Health Services, Makerere University  
P.O. Box 7072, Kampala, Uganda  
TELEPHONE (OFFICE): 0312109456  
MOBILE NUMBER: 0772 490096  
EMAIL: hnabudere@gmail.com  

26. Dr Robert Basaza  
Research Scientist  
Supporting Use of Research Evidence for Policy (SURE Project)  
College of Health Sciences, Makerere University  
New Mulago Hospital Complex, Administration Building, 2nd Floor  
P.O Box 7072, Kampala, Uganda  
TELEPHONE (OFFICE): 0312109456  
MOBILE NUMBER: 0701428474  
EMAIL: rbasaza@gmail.com  

27. Dr. Rhona Mijumbi  
Project Officer  
Supporting Use of Research Evidence for Policy (SURE Project)  
College of Health Sciences, Makerere University  
New Mulago Hospital Complex, Administration Building, 2nd Floor  
P.O Box 7072, Kampala, Uganda  
TELEPHONE (OFFICE): 0312109456  
MOBILE NUMBER: 0772 607 787  
EMAIL: mijumbi@yahoo.com  

28. Mr. Robert Apunyo  
Programs Manager  
Kabano Research and Development Centre  
PLOT 487 Kyengera, Masanda Zone  
P.O Box 35906 Kampala  
Mobile: 0712 855 013  
Email: rapuny@yahoo.co.uk