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Twelve years ago, the Fellowship Program was launched at Makerere University School of Public Health. Since that time, this program has created a great impact on health workforce development. As I write, we have so far trained 107 long-term Fellows and 207 Medium-term Fellows, majority of whom are employed in high-level positions in government and non-government organizations in Uganda and elsewhere. In the first five years, the program focused on supporting Fellows to acquire skills in managing HIV/AIDS programs. However, in the past seven years, the program focus expanded to encompass other health programs including maternal and child health, health informatics, malaria and tuberculosis, among others. Beginning 2014, our focus will now be on supporting the public health sector through the Uganda Public Health Fellowship Program and District-led Programming.

Our graduates have made significant contributions in the leadership and management of health programs including evaluation of health programs, coordination of multi-donor health agencies, expansion of quality improvement efforts in the country, and improvement of health reporting and use of data to inform decision-making, among other achievements. Our graduates hold positions within the Ugandan Ministry of Health and other government Ministries, Departments and Agencies, and also in the private sector.

In 2012 the Fellowship Program received additional funding from the US Centres for Disease Control and Prevention (CDC), for another five-year phase, and this in itself is a vote of confidence from the funders, that we should be proud of. This funding will continue to support existing Fellowships and graduate training at the School of Public Health. In this new phase we are exploring further adjustments that will ensure relevance and continued contribution to the strengthening of leadership of health programs in Uganda, including stronger partnerships with the Public Sector. On this note, let me thank our development partners, CDC and the US Government in particular for sustaining this effort; the Fellows who have made us shine, the host institutions that we have worked with over the years, and finally the MakSPH staff for the work well done.
Word From The Principal Investigator

Over the past few months, I have been reflecting on the extent to which the Fellowship Program has been able to thrive for the past 12 years. When we started the Fellowship in 2002, we did not know that this program would make such a great impact on health workforce development like we have witnessed over the years. I am therefore proud and excited to be associated with this program that has equipped young leaders and managers with the skills that they need to manage health programs. As we begin our journey for the next couple of years, it is important to mention that our focus will extend into the public sector, and our capacity building efforts will aim to support public health workforce development moving forward. We hope to build on the 12 years of experience that we have had to inform future program implementation and will enrich this experience with new insights from our partners, including the Ministry of Health and CDC.

Over the past 12 years, we have relied on the support from the host institutions, the academic and host mentors, to supplement the efforts of the core program staff. It is my pleasure and honour, therefore, to express our sincere gratitude to the host institutions for offering an opportunity to our Fellows to learn how to manage and lead health programs from a practical point of view. We value the role of stakeholder involvement in the training of transformative leaders in Uganda, and therefore pledge to continue to work with different institutions to fulfil our mandate of training and nurturing future leader-managers of health programs in Uganda.

We would like to thank the academic mentors for their strong commitment and dedication towards the Fellowship Program goals and objectives. Special regards go to all the academic and roving mentors, including Dr Noerine Kaleeba for her unstinted ‘home-grown’ mentorship to all the Fellows; Dr Olico Okui who has been with us since inception of the program; and Drs Fred Makumbi, Dr Noah Kiwanuka and Assoc. Prof Nazarius Tumwesigye for offering statistical support to the Fellows.

We are highly indebted to CDC for the technical and financial support rendered to the program and to the program staff for their dedication and enthusiasm to make this program a success.

Last but not least, we are grateful to the Dean, Makerere University School of Public Health, for his support to the program, and the CDC Project Officers and Activity Managers for guiding program staff in all aspects necessary to meet donor requirements and continue to be funded over the years.

Prof David Serwadda
Principal Investigator
MakSPH-CDC Fellowship Program
Between 2002 and 2013, the program, the MakSPH-CDC Fellowship Program (MakSPH) with support from Centers for Disease Control (CDC) implements a Fellowship training program known as MakSPH-CDC Fellowship Program. The objective of this program is to enhance health program leadership and management capacity in Uganda. For the last 12 years, the areas of focus included HIV/AIDS, maternal and child health, malaria, tuberculosis; public health informatics, and other health-related programs. The program, which began in 2002, provides long-term and medium-term Fellowships, and short courses.

Long-term Fellowships: The long-term Fellowship is a 2-year, non-degree fulltime program offered on a competitive basis to Ugandan nationals with a Master’s degree in Public Health, Medicine, Nursing, Monitoring and Evaluation, Maternal and Child Health and other health-related disciplines. The Fellowship aims at training transformative leaders in health who are analytical and can work effectively in multidisciplinary teams. The training methodology takes on a hands-on approach that is guided by a set of six main domains (interpersonal and effective communication, strategic thinking, management and leadership, monitoring and evaluation, information technology, and mentorship, coaching and support supervision). For each domain, a set of core competencies has been specified. Core competencies refer to the skills, attitudes and practices that Fellows should acquire during the course of the Fellowship. Overall, 13 core competencies were identified for the six domains. Long-term Fellows are attached to selected institutions for apprenticeship. The apprenticeship accounts for 75% of the training. The remaining 25% is reserved for Fellows to attend multi-disciplinary short courses at MakSPH to enhance their academic competences. During the apprenticeship, Fellows are placed under the guidance of a designated host mentor. An academic mentor, who is usually a member of staff from Makerere University College of Health Sciences, is assigned to guide the Fellow through the academic components of the Fellowship.

One hundred and seven (107) long-term Fellows have completed the program since inception in 2002. Thirteen of these Fellows will be graduating today. Our graduating Fellows have contributed to leadership and management at their respective host institutions where they have strengthened monitoring and evaluation systems, improved data management systems, contributed to fundraising and resource mobilization, and initiated pilot health interventions that have since been replicated in other parts of Uganda. Seventy three (73) institutions have hosted Fellows since 2002. We would like to express our sincere gratitude to the institutions that have hosted the graduating Fellows. These institutions include: AIDS Control Program, Jinja District, Center for Health, Human Rights and Development; AIDS Information Center, Central Public Health Laboratories, National TB and Leprosy Program, and Reach Out Mbuya, among others. Without their support, we would definitely not be able to support the Fellows to attain their training objectives. Beginning next year, the Fellowship Program focus will shift to support the Public Health Sector, with majority of the placements taking place in the Ministry of Health and other public sector agencies. Under this arrangement, the program will introduce five Fellowship tracks over the next five years, beginning with Field Epidemiology in January 2015. The other tracks (Monitoring and Evaluation, Laboratory Systems, Public Health Informatics, and Health Economics) will be introduced in subsequent years. Additional information about our work can be obtained from the program website at: http://www.musphcdc.ac.ug

Medium-term Fellowships: Medium-term Fellowships are offered for a period of eight months to in-service professionals working in organizations involved in health-related activities. The program initially offered two medium-term Fellowships in Monitoring and Evaluation (M&E) and Continuous Quality Improvement (CQI). However, beginning in 2014, the two courses were merged into one course known as the Health Services Improvement Course. The purpose the Medium-term Fellowship is to build institutional capacity through training individuals in specialized fields. The training methodology used is modular and work-based in nature, allowing trainees to undertake courses while continuing with their employment. Overall, 207 Fellows from 95 institutions have completed their training since 2008. Between 2008 and 2013, our support was largely tilted towards the private sector. However, in 2014, all the 42 Fellows were drawn from the public sector at district and sub-district levels. In the next five years, our focus will largely be geared towards increased support to the district local governments (through our District Capacity Building Program) in order to support the Ministry of Health’s efforts to strengthen district-led programming.

Short courses: Between 2002 and 2013, the program offered off-site short courses to mid and senior level managers and staff involved in HIV/AIDS activities at national, district, facility and community levels based on institutional training needs. Short courses offered include grants and proposal writing, monitoring and evaluation, design and implementation of HIV/AIDS programs, behavior change communication, strategic leadership and management, among others. Over 3000 individuals were supported through short courses during the 11-year period. These courses were held in several districts including Bugiri, Namutumba, Hoima, Kitgum, Kasese, Luweero, Kamuli, Iganga, Wakiso, Mbale, and Mayuge, Amolatar, and Moyo, among others.
STRENGTHENING THE IMPLEMENTATION OF TB/HIV COLLABORATIVE ACTIVITIES TO REDUCE THE TUBERCULOSIS BURDEN IN UGANDA

ABOUT THE FELLOW

Daniel Mwanja Mumpe holds a Master’s Degree in Public Health (MPH) of the Institute of Tropical Medicine, Belgium and a Bachelor’s Degree in Medicine and Surgery of Mbarara University of Science and Technology, Uganda. After his academic studies, Daniel worked as a clinician, later coordinating an epidemiological research study and an infectious disease control project where he developed an interest in building a career in infectious diseases control. Daniel joined MakSPH Fellowship in February 2013 and was placed at the National Tuberculosis and Leprosy Program (NTLP) for his apprenticeship. The NTLP is the technical unit within the National Disease Control Department of the Ministry of Health that is tasked with overseeing and leading Tuberculosis (TB) control activities in the country, including planning, training, resource mobilization, establishing policy and standards, and ensuring quality of implementation through surveillance and monitoring and evaluation of the relevant performance parameters. While at the NTLP, Daniel was tasked to strengthen the implementation of TB-HIV collaborative activities to reduce the TB burden. During the course of implementing the assigned duties, he strengthened his leadership skills and management skills. The key tangible achievements of his attachment include national guidelines for the implementation of intensified TB case finding and provision of Isoniazid Preventive Therapy for people living with HIV/AIDS; and development of a training package for health workers to implement the TB-HIV collaborative activities. Daniel has had the opportunity to design and implement a study to determine the treatment outcomes for multi-drug resistant TB in Uganda and factors affecting these outcomes, which findings will help to guide the scale-up of MDR TB services in the country. His career prospect is to become a specialist in infectious diseases control and programming. About his 2-year Fellowship training, Daniel summarizes it in the following words: “It [the Fellowship Program] is a blend of opportunities for leadership growth: overcoming the challenges that come with host institution assigned responsibilities plus the inspiration and motivation from the mentors did it. I am confident to take on any leadership role.”

Key fellowship responsibilities and accomplishments

Offer technical assistance in the development of implementation guidelines for ICF and IPT:
I reviewed literature on TB prophylaxis and made a presentation on the findings to a team of staff from the AIDS Control Program (ACP) and NTLP that had been selected to develop the national ICF and IPT guidelines. The findings guided the writing team to select an IPT regimen appropriate for Uganda which has now been disseminated for implementation throughout the country.

Review the monitoring and evaluation framework for TB-HIV collaborative activities to include IPT:
I developed performance targets, performance indicators and means of verification to guide the monitoring of IPT activities. These aspects have been incorporated into the monitoring and evaluation framework of the TB-HIV guidelines.

Review the training package of TB-HIV collaborative activities:
I reviewed TB-HIV training guidelines and identified sections of the training guidelines that needed to be updated. I also did a performance-based training needs assessment of the health workers involved in TB-HIV management to give further guidance to the review of the TB-HIV training materials. I worked together with a consultant to guide a team of selected technical staff to update the various sections of the training materials including the methods of training delivery.

Coordinate training of health workers to implement TB–HIV collaborative activities:
I guided NTLP in selecting 30 health workers in Gulu district to attend a five-day training on TB-HIV collaborative activities to ensure effective implementation of TB/HIV activities in Gulu. I also guided the selection of trainers to ensure that the training quality is maintained. I later supported the trainers in the delivery of some sessions and clarifying any issues when called upon.
Assess the implementation of TB infection control in the regional referral hospitals in Uganda: I wrote a concept note on the need for an assessment of infection control practices in six regional referral hospitals (RRH) and obtained 21 million Uganda Shillings from SUSTAIN to support the implementation of this activity. I led the data collection exercise which was done in Soroti, Moroto, Lira, Kabale, Mubende and Fort Portal RRH from 30th August – 6th September 2014. The assessment team identified the gaps in infection control practices that needed to be addressed to accredit these hospitals to treat MDR TB. By far, five of the six hospitals that were assessed have been accredited to treat MDR TB.

Support zonal TB leprosy supervisors to conduct quarterly performance reviews: Together with the NTLP team, we conducted quarterly performance review visits to the NTLP zones. During the visits, I supported zonal TB supervisors to review their performance and make activity plans for the subsequent quarters.

Make preparations for the NTLP performance review: I designed data collection tools that were used to assess the NTLP program performance in the implementation of TB-HIV collaborative activities. This tool sought to compare the TB-HIV services provided by the program with the optimum required norm. I was also part of the team that went out to the field to assess the performance of the national TB program. A performance review report has been written and this has guided the writing of the 2015/16-2019/20 NTLP Strategic Plan.

On the whole, my involvement in these activities helped me to gain knowledge on TB program management and strengthened my ability to conduct critical problem analysis, program monitoring and evaluation and staff mentoring and coaching. I can now confidently manage a program.

Other achievements

Support staff to conduct operations research and document the findings: I supported staff at the NTLP to conduct operations research studies which included: 1) Using Management and Organizational Sustainability tools to strengthen management – a pilot study that was conducted at the NTLP central unit over a period of one year, and 2) Assessment of the use of routinely collected data for decision making by the Zonal Tuberculosis and Leprosy Supervisors (ZTLS). The findings of these studies have been documented; and I was a co-author on two abstracts that were written from the study findings. These abstracts were accepted for oral presentation at the 45th International Union against TB and Lung Disease (IUATLD) Conference held in Barcelona, Spain, from 28th October – 1st November 2014.
Lead the establishment of a newsletter for the NTLP: I headed the establishment of the NTLP newsletter that is meant to serve as NTLP’s mouthpiece, to communicate program achievements and advocate for increased support of TB care services. I sourced for articles from various NTLP collaborators and edited TB technical aspects of the articles. I worked together with a hired communications consultant to produce the first-ever edition of the NTLP newsletter. We are currently working on the second edition of the newsletter as it grows stronger. A TB implementing partner, TRACKTB, has hired a fulltime communications expert to help edit the subsequent issues.

Establish a system for reviewing Multi-drug resistant tuberculosis (MDR TB) program performance: Until April 2014, there had been no system established at NTLP to periodically review the organization’s performance in the management of MDR TB. I developed standard operating procedures to guide the continuous periodical assessment of MDR TB patient treatment outcomes to facilitate improved patient management. The cohort review is now done at quarterly intervals. To increase its service improvement benefit for the patients, the cohort reviews have now been decentralised to the zonal level where more clinicians can participate.

Review the national MDR TB management guidelines: I was part of a technical team that participated in the revision of the national guidelines for MDR TB management. I took lead in the review and re-writing of the first chapter of the guidelines that describes the development of multi-drug resistant TB (MDR TB) and its risk factors; and another chapter on case finding. The review process is not yet complete; a hired consultant is incorporating our reviews into a finer version.

Contribute to development of Paediatric TB guidelines: I contributed to efforts to improve paediatric TB management in the country by assessing paediatric TB service coverage in two (Fort Portal and Mubende) regional hospitals. The findings guided NTLP in drafting the first-ever paediatric TB guidelines. I particularly contributed to writing of the introduction section of the guidelines.

Develop a strategy for changing TB treatment regimen from the eight month course to the six month course: I contributed to the planned change from the eight months’ treatment course to a six months’ one. This change has been adopted following evidence of a better treatment outcome and less costs incurred with six a months’ treatment course. I designed a phased patient enrolment strategy to minimize drug wastage as NTLP transitions into to the new guidelines.

Innovations and creativity at the host institution: I realized that while many TB patients come for drug refills, many patients still miss the treatment monitoring investigations. In response, I designed a workflow guide that specifies all activities that health workers should do for each patient at a given visit to improve treatment with monitoring investigations. This tool has been piloted in the Eastern NTLP zone for about two months now, and early results indicate an increase in the number of patients who have treatment with monitoring investigations done.

Training and capacity building conducted at the host institution: In addition to other training activities already mentioned, I delivered two sessions: (i) a half-day session on TB treatment and side effects of the drugs; and (ii) treatment of TB in special situations at the training of District TB and Leprosy Focal Persons (DLFPs) in Mayuge district. The training, whose aim was to impart knowledge and skills to the trainees on how to manage the District TB and Leprosy program, was conducted at St Francis Buluba Hospital from July 7th – 31st, 2014.

Communication, presentations & publications

a) Print media
I wrote and published the following newspaper articles:
- We should stop the spread of TB, New vision Sunday, March 13th, 2013
- Ministry of Health should invest more in rapid diagnostic test kits for malaria, New vision, Wednesday, May 1st, 2013

b) Conference presentations

c) Manuscript submitted to a peer-reviewed journal

d) Manuscripts in preparation
Outcome and experiences of patients treated for Multi-drug resistant tuberculosis in Uganda.

Programmatic Activity Summary

Assessing the factors influencing multi drug resistant tuberculosis outcomes in Uganda

Introduction: Multi drug resistant (MDR) TB has become a big problem in many countries over the last 20 years. There is increased enrolment of MDR patients for treatment, however many patients have unsuccessful treatment. The global treatment completion rate among patients enrolled on MDR TB treatment in 2010 was...
48%; worse in Africa where only 36% completed treatment. Whereas Uganda started implementing MDR TB treatment in 2009 and plans to scale-up implementation, there has not been a comprehensive evaluation of treatment outcomes and the contextual challenges, to guide the national scale-up.

Objective: This study sought to determine the culture conversion rate at 6 months of treatment, the proportion of patients initiated on treatment with the recommended regimens and the association between individual patient, adherence and regimen related factors.

Methods: This was a mixed-methods retrospective study conducted in four (Mulago, Arua, Mbarara and Kitgum) hospitals. Routine program management data of all patients who were confirmed to have MDR TB between October 2009 and July 2013 and who had been initiated on treatment 6 or more months prior to the study were eligible for the quantitative part of the study. The qualitative part utilized 32 in-depth and 17 key informant interviews purposively selected to explore the views and experiences that affected the choice of treatment regimen and adherence to the treatment regimen. Univariate and multivariable analysis of quantitative data was done using SAS 9 software. Culture results at six months of treatment were the dependent variable while treatment regimens used, duration between treatment initiation and diagnosis; and patient socio-demographics data were the independent variables. Thematic analysis of qualitative data analysis was done manually.

Results: There was a 96.6% culture conversion rate at 6 months of treatment; all diagnosed patients were initiated on treatment with the recommended regimens. There was no significant association between treatment outcome and the socio-demographic characteristics, regimen used and the duration between diagnosis and treatment initiation. Patient adherence to treatment was mainly motivated by the desire to get cured. The main factors which affected treatment adherence included: lack of drug supplies, lack of treatment monitoring results, drug side effects, inadequate psychosocial counselling and inadequate preparation of patients for treatment, lack of community support, treatment-related costs, and lack of integration with other. Qualitative findings indicated that health workers collectively determine the patient treatment plan which has encouraged adherence to the recommended treatment regimens. Though, regular stock-out of drugs has caused interruption of treatment and delays in treatment initiation it not brought about use of inappropriate regimens.

Conclusion: The interim treatment outcome is good and NTLP recommended regimens are used to treat MDR TB. Despite this, there are many health system factors which may affect patient adherence to treatment and use of the recommended regimens. These need to be addressed to maintain the good treatment outcome.

Policy and public health implications: This study emphasizes the need for holistic patient care of chronically ill patients. In addition, whereas the desire for being cured of the disease motivates patients to adhere to treatment, several health and community system issues need to be addressed in order to achieve adequate preparedness for treatment initiation and treatment adherence.

ABOUT THE NATIONAL TB AND LEPROSY PROGRAM

The National TB and Leprosy Program (NTLP) started in 1990 as a pilot project covering 10 districts; it was later scaled-up and achieved complete country coverage in 1995. It is the technical unit within the National Disease Control Department of ministry of Health that is tasked with leading TB and leprosy control activities in the country. The NTLP operations are integrated in the three levels of the national health system. The national level, also referred to as the central unit, is headed by a Program Manager. District health officers supervise the planning, implementation, and; monitoring and evaluation of the disease control interventions in their respective districts. The regional level comprises of a number of districts under a Zonal Supervisor who gives technical assistance to district level on behalf of the national level. The NTLP envisions a Uganda free of TB and Leprosy. Further details about the NTLP can be obtained from the program website at: http://health.go.ug/mohweb/node/14
IMPLEMENTING THE NUTRITION ASSESSMENT, COUNSELING AND SUPPORT (NACS) COMPONENT OF THE PARTNERSHIP FOR HIV-FREE SURVIVAL INITIATIVE AT TASO

ABOUT THE FELLOW

Francis Lwanga holds a Diploma in Clinical and Community Medicine from Fort-Portal School of Clinical Officers, an Advanced Diploma in Health Tutorship from Makerere University, a BSc. in Human Nutrition and Dietetics from Kyambogo University and a Master of Public Health Nutrition from Makerere University. Francis’ career goal is to become a recognized academician in public health nutrition and programming. Prior to joining the Fellowship, Francis worked as the Academic Registrar for the Uganda Institute of Allied Health and Management Sciences, Mulago. In February 2013, Francis joined the MakSPH-CDC Fellowship Program and was placed at The AIDS Support Organization (TASO). While at TASO, Francis coordinated the Nutrition Assessment, Counseling and Support (NACS) component of the Partnership for HIV-free Survival Initiative (PHFS) in Jinja, Manafwa and Tororo districts. He successfully rolled out the NACS activities in 70 health facilities including 11 TASO centers. He developed the NACS implementation guidelines and standard operating procedures for TASO and has been a member of the national PHFS M&E task force which guided the Ministry of Health Resource Center in upgrading the national data collection tools to include nutrition variables. The Fellowship has enabled Francis to get a thorough understanding of the national and regional implementation protocols for nutrition programs which are important in nutrition policy and program design. He has been exposed to majority of key nutrition stakeholders in the country and beyond. Coupled with the attainment of oral and written communication skills, these attributes are a major asset for his future personal career growth. In his own words, Francis sums his 2-year apprenticeship in the following words: “The Fellowship program has not only imparted into me the practical skills in health leadership and management but has also improved my instructional skills beyond the classroom to the entire public. I can now use my improved oral and written communication skills to advocate and transform society in matters related to public health nutrition”

Key Fellowship responsibilities and achievements

The achievements during the fellowship are a reflection of my terms of reference which included:

Spearhead the implementation of NACS activities within the PHFS initiative in Jinja, Manafwa and Tororo districts

- I coordinated activities that led to the successful national launch of the Partnership for HIV-free Survival (PHFS) Initiative.
- I acted as the focal person for PHFS/NACS at TASO
- I developed the PHFS scale-up plan that covered 46 public health facilities & 8TASO centers of excellence
- I scaled-up NACS and continuous quality improvement (CQI) activities from 12 pilot health facilities to 46 including 8TASO centers.

Provide technical support for capacity building of service providers for NACS and quality improvement in the three project districts

- I coordinated all NACS training activities in the 11 TASO centers and 56 public health facilities in Jinja, Manafwa and Tororo districts. Over 500 community workers including village health teams (VHTs) and expert clients have also been trained in NACS across the 3 districts.
- I developed nutrition support visit/mentorship guidelines for TASO teams that support the public health facilities
- I supported TASO to orient and mentor district teams in Jinja, Manafwa and Tororo in the area of PHFS/NACS

Implement strategies to create demand for NACS within the maternal and child health service points in the three project districts

- I provided technical guidance in procurement of nutrition information, education and communication (IEC) materials for use in community and NACS contact points
• I offered technical guidance in the formation of District Nutrition Coordination Committees. These committees never existed but are currently operational in the three districts.

• I offered technical guidance in the training of TASO drama groups in the dissemination of nutrition messages across all centers. These groups have disseminated nutrition messages in the communities.

Offer technical support in strengthening the district health service delivery system to integrate NACS into prevention of mother-to-child transmission (PMTCT) of HIV interventions in the three project districts

• I provided technical guidance in the procurement and supply of anthropometric equipment (including weighing scales, measuring boards and MUAC tapes) to all TASO centers and over 56 public health facilities in the three project districts.

• I liaised with CDC and the regional referral Hospitals to support TASO centers & the public health facilities to acquire Ready to Use Therapeutic Feeds (RUTF) which were previously not being supplied.

Take lead in strengthening the monitoring and evaluation processes for NACS within PMTCT/ MNCH programs in the three project districts

• I was part of the National PHFS M&E taskforce that guided the Ministry of Health to update the national data collection tools (HMIS) to include nutrition variables which were lacking. Today, the national data collection tools do capture the nutrition variables.

• I provided technical support to procure nutrition data collection tools for TASO centers & the public health facilities.

• I have mentored TASO and public health staff in matters regarding nutrition status assessments and recording; the teams are now able to report on the nutritional status of clients.

• As part of the National M&E PHFS task force, I provided technical guidance in development of the National PHFS evaluation plan.

Link up with other PHFS-supporting partners like Food and Nutrition Technical Assistance (FANTA 3) and Applying Science to Strengthen and Improve Systems (ASSIST) as well as Ministry of Health to plan and execute in-country learning sessions

• I successfully coordinated four PHFS learning sessions. The sessions, organized at national level, brought together health workers from supported health facilities to share implementation experiences, lessons learned and challenges encountered during implementation of PHFS activities.

Give TASO a nutrition strategic direction

• I developed the nutrition implementation guidelines.
for NACS and standard operating procedures for use by TASO centers
• My programmatic activity on 'applying a positive deviance hearth model to strengthen community NACS' has offered TASO an opportunity to strengthen the community arm of NACS
• I built capacity for nutrition in all the 11 TASO centers

Throughout the fellowship, I have gained enormous experience in working with the different sectors; an experience that has enabled me to gain a deeper understanding of the health delivery systems which is an important element of public health nutrition programming and policy. I have clearly learnt challenges affecting delivery of nutrition services at national, local government and community levels. The fellowship has transformed me into a leader of health/nutrition programs who can achieve results under increasingly complex and challenging conditions. These experiences have enabled me to build strong foundations in the areas of team building, networking and benchmarking, advocacy and scientific writing.

Communication, presentations & publications

a) Print Media
I published four newspaper articles as shown below:

iii. Why escape HIV only to die of hunger, The observer, Monday, July 15th 22013
iv. That heart attack can be stopped, Sunday Vision, April 7th 2013

b) Conference presentations
ii. Lwanga F, Wanyenze R, Nabiryo C, Matovu JK, Orach C. Food security and Nutritional status of children residing in sugarcane growing communities of Jinja district-East-central Uganda”. Oral presentation at the 10th Joint Annual Scientific Conference, Kampala, Uganda: September 24th -26th, 2014. This paper was also presented at the 10th Uganda Paediatric Association, Kampala, Uganda: November 13th -14th, 2014


c) Manuscripts submitted to peer-reviewed journals
In the course of the Fellowship, I have written and submitted 2 manuscripts as shown below:


Programmatic activity summary

Applying a Positive Deviance Hearth Model to Strengthen Community Nutrition Assessment, Counseling and Support in Jinja District

Introduction: This programmatic activity was part of a broader plan aimed at developing a nutrition strategic direction for TASO. The activity aimed at using the positive deviance (PD) model and positive deviance inquiry (PDI) to develop a protocol for use by TASO to strengthen community Nutrition Assessment Counseling and Support (NACS). The purpose of the PDI was to enable the Fellow and community partners identify the unique practices of some household members that allow them to cope with nutritional and food insecurity challenges more successfully within the same community and similar resources. Such resilient families provide lessons for those with malnourished children, in line with the positive deviance model, thereby forming the basis for designing a program for strengthening community NACS. The activity had four specific objectives including: 1) conducting a food security and nutrition status survey 2) conducting a positive deviance inquiry (PDI), 3) identifying feeding, caring and health-seeking practices from the survey and PDI 4) designing a PD hearth implementation protocol.

Food security and nutrition status survey: Busende sub-county (A predominantly sugarcane growing community) with the highest estimated prevalence of malnutrition was purposively selected using records from Nalufenya nutrition unit in Jinja District. Within Busende sub-county, Nahtambala parish was randomly selected. All households with children aged below five years in this parish were investigated. Food security survey data were assessed using the FAO Household Food Insecurity Access scale. Nutritional status was assessed using Height-for-Age, Weight-for-Age and Weight-for-Height to measure stunting, underweight and wasting respectively. We performed statistical analysis with STATA to ascertain relationships with predictor variables. Survey results reveal that, out of the 646 children assessed, 33.3%, 27.4% and 18% were stunted, underweight and wasted,
respectively. Out of the 382 households studied, 12% were food secure while 14.7%, 23.6% and 49.7% had mild, moderate and severe food insecurity, respectively. Of the 95 households with wasted underweight and stunted children, the majority (85.3%, 88.3% and 91%, respectively) were food insecure. The percentage of households with children who are malnourished increased with increase in number of children in the households (p=<0.001). The prevalence of malnutrition and household food insecurity was found to be extremely high in this sub-county.

Identifying feeding, caring and health-seeking practices survey: Before conducting the PDI, we identified families with well-nourished (positive deviants) and malnourished (non-positive deviant) children from the above-mentioned survey. We then administered a questionnaire to investigate the feeding, caring and health-seeking practices in both categories. This helped us identify good and harmful practices contributing to the malnutrition status of children in positive deviant (PD) and non-positive deviant (NPD) families. Survey results indicated that good feeding practices were related to optimal breastfeeding practices, quality complementary feeds and active feeding of children. Good care practices involved birth control, mothers staying with children all the time, better sanitation and fathers’ involvement in childcare. Good health-seeking behaviors included: prompt attention to child sickness, mothers’ involvement in taking decisions to take the child for health care, prompt management of diarrheal diseases, avoiding of local herbs in management of diseases, continuation of breastfeeding during illness, and complete immunization. Poor/harmful practices included; early weaning limited breastfeeding sessions, limited proteins in child’s diet, early and late complementary feeding, limited sessions of complementary feeding large family size, poor child spacing, children looked after by grandparents, mothers not carrying children with them when outside homes, fathers’ failure to recognize a sick/malnourished child, limited time for child care by the fathers, delay in taking decisions to take child to health facility, failure to keep ORS at home, lack of knowledge on feeding a child with diarrhea, self-medicating children, incomplete immunizations, and unhygienic latrine facility.

Designing a PD hearth implementation protocol: Using survey findings, we developed a positive deviance implementation protocol to guide the NACS program. The protocol will be piloted at village level. If successful, TASO shall scale-up this intervention to other locations of the three districts. Piloting of the intervention is expected to run for six months starting in February 2015.

ABOUT TASO

The AIDS Support Organization (TASO) is an HIV/AIDS service organization founded in 1987 by Dr. Noerine Kaleeba and 15 other colleagues. From a small support group, the organization has evolved into an NGO with eleven service centers of excellence and four regional offices covering most parts of Uganda. TASO is guided by four key strategic objectives; Combination HIV Prevention, Care and Treatment, Social support, and Health System Strengthening at facility and community levels. With a vision of “A world without HIV and AIDS”, TASO exists to contribute to a process of preventing HIV infection, restoring hope and improving the quality of life of persons, families and communities affected by HIV infection and disease. Additional information about TASO can be obtained from: http://www.tasouganda.org.

The protocol will be piloted at village level. If successful, TASO shall scale-up this intervention to other locations of the three districts. Piloting of the intervention is expected to run for six months starting in February 2015.
ABOUT THE FELLOW

Joan Kabayambi holds a Master's Degree in Public Health Leadership from Uganda Christian University and a Bachelor of International Relations and Diplomacy from Nkumba University. Joan also received additional training in financial management, project planning and management, and human resource management from Uganda Management Institute and Makerere University Business School. Joan’s specialized areas of interest include: Maternal and child health, obstetric fistula, family planning, and adolescent sexual and reproductive health. Prior to joining the Fellowship, Joan was the Executive Director at Hope Again Fistula Support Organization (HAFSO). She was attached to Center for Health, Human Rights and Development (CEHURD) during the 2-year Fellowship apprenticeship. CEHURD is an indigenous, non-profit, research and advocacy organization, which is pioneering the justifiability of the right to health in the East African Region. While at CEHURD, Joan supported two research projects, one at facility and another at community level. She also supported CEHURD staff in monitoring and evaluation with emphasis on result- and target-oriented performance. This exposure enabled her to interface with several stakeholders at international, national and local levels. Joan also acquired and enhanced her skills in program leadership and management, communication, strategic thinking, monitoring and evaluation and research. In her own words, Joan had this to say: “The fellowship has transformed me; the way I came in is absolutely not the way I am going out. Given another opportunity, I would take this fellowship journey again. I thank God for the opportunities that came with the fellowship; and my family for allowing me to undertake this professional program”.

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Mentors
Host Mentor:
Mr. Moses Mulumba, LLB, Dip (LP), LLM, M.Phil
Executive Director, CEHURD

Academic Mentors
Dr Elizabeth Ekirapa, MBChB, MPH, MPH (Health Economics), PhD
Lecturer, Makerere University School of Public Health

Dr Jolly Beyeza, MBChB, MMed (Obs/Gyn), PhD
Senior Consultant, Obstetrics and Gynecology, Mulago Hospital

Key Fellowship responsibilities and accomplishments

Review of CEHURD documents to understand its work
• I held several meetings with all staffs on a one-on-one basis to understand each person's work
• I reviewed my terms of reference (ToR) to ensure that they reflected my career plans and Fellowship expectations, and developed a 2-year planner based on the ToR
• I reviewed CEHURD documents (the strategic plan, publications, and the draft Human Resource Manual) in order to understand the organization’s strategic direction, and ascertain how I would fit into this direction as a Fellow. I noted some inconsistencies in the Strategic Plan and communicated them to the Host Mentor. A consultant was hired to review the Strategic Plan. I also conducted a SWOT analysis to inform the revision of the Strategic Plan, and development of an M&E Framework.

Conduct Research, documentation and publications
• I conducted two research projects as the principal investigator: The first project; “Implementation of Maternal death reviews recommendations in 6 health facilities in 5 districts” was aimed at generating findings that would support Petition No. 16 on the state of maternal health in Uganda. The second project; “Community participatory model to reintegrate fistula women after surgery in 2 districts: a pilot study” informed the design of a model for reintegrating women repaired of obstetric fistula into the community using a participatory reflection approach
• I documented three cases on maternal health violations in Gulu and Kiboga and forwarded them to the Strategic Litigation Program at CEHURD for further pursuance. These cases have now been used to support CEHURD’s petition that seeks to declare that non-provision of essential maternal health commodities to public health facilities is a violation of mothers’ constitutional rights to health.
• I was part of a team that developed three proposals, including one on social integration of obstetric fistula, that were submitted to different funders for possible funding.
All proposals are still under review.

Support CEHURD institutional development
- I supported management to develop a staff appraisal and evaluation system to measure staff performance. At the moment, staffs can participate in the evaluation of their performance.
- I conducted staff trainings in M&E as well as in result- and target-oriented work plan development and assisted staff to integrate obstetric fistula into their routine activities.
- I supported two staffs to write and submit abstracts to conferences. These abstracts were eventually presented at Eastern, Central and Southern African Obstetrician and Gynecologists meeting in Kampala in October 2014.
- I mentored three staff members (Program Officer, Community Empowerment Officer, and Community Officer) in how to carry out research and document results of their work.

Support CEHURD program work on coalition on maternal health
- I attended coalition meetings on behalf of CEHURD aimed at lobbying parliament to stop maternal deaths in Uganda. These meetings helped me to network with different advocacy agencies and thus learned more in areas of advocacy.
- I facilitated at the media fellowship program where I presented a paper entitled "Obstetric fistula: the Silent Public Health Crisis". This paper also highlighted the link between obstetric fistula and abortion.
- I wrote an article on ‘Trends in maternal health and the Millennium Development Goals’ with a focus on Uganda. This article was published in the CEHURD newsletter.
- I represented CEHURD at 2 international conferences on Global Health in Rome and Barcelona.
- I attended the launch of the International Day of Obstetric Fistula in New York, USA.

Other achievements
- I attended a Rotary Convention in Portugal in 2013 and in Sydney in 2014 to fundraise for obstetric fistula. A reintegration project is ongoing in partnership with Nakasero Hospital.
- I led the editorial work on 4 thematic papers that were submitted to CEHURD for further consideration.
- I represented the Executive Director at the National Health Symposium in teenage pregnancy during the safe motherhood week in Kampala November 15, 2013.
- I attended the dialogue on maternal mortality review and reduction by Association of Uganda Gynecologists’ and Obstetricians (AUGO) and

Fellow (first on the right) conducting an in-depth interview with women repaired of OF in Mulagi – Kyankwanzi
Parliament of Uganda on Kampala 28th July 2013.

- I facilitated at the CEHURD health camp in Buikwe, to raise awareness of health conditions that affect most communities. I sensitized community members about the causes and prevention of obstetric fistula. This enhanced my public speaking and seven women were identified for reconstructive surgery.

In brief, the fellowship experience enhanced my leadership, analytical, communication, and negotiation and networking skills; specifically, around working with lawyers in maternal health networking with different stakeholders. The Fellowship training also challenged me with multiple deadlines, thereby teaching me to multi-task. My fellowship placement exposed me to research work and working with communities and this further improved my interpersonal communication, analytical skills as well as use of information technology applications.

Communications, Presentations, and Publications

a) Print media
I published nine newspaper articles; six (6) in the New Vision and three (3) in the CEHURD newsletter, as shown below:

- Village health teams can offer hope to women with fistula. The New Vision of April 10, 2013.
- I am dry and accepted: a victory of a woman with repaired fistula. The New Vision of Wednesday 1, October 2014.
- The need to operationalize the fistula strategy for Uganda.

Published in the CEHURD quarterly newsletter of May -August 2013 news letter.

b) Conference presentations
I made eight presentations at national & international gatherings, as shown below:

- Kabayambi J, Matovu JK. Obstetric Fistula as Human Rights challenge in sub-SA-findings in Uganda ACODEV 10th Oral presentation at the Anniversary Symposium on Health, Kampala, Uganda: July 18, 2014

Programmatic Activity Summary

Using a community participatory reflection approach to support re-integration of women who have undergone fistula surgery in Central Uganda

Introduction: Women who have been repaired of obstetric fistula (WROF) often continue to be socially isolated, discriminated and stigmatized and need support to reintegrate them into communities. We implemented a community participatory reflection action approach
(PRA) to support WRoF’s reintegration into the community in central Uganda.

**Objectives:** We set out to (i) identify challenges WRoF face in getting reintegrated into the community and (ii) develop and implement a simple, affordable, feasible, acceptable, sustainable and community-owned intervention to address identified challenges using a community PRA as the guiding model.

**Implementation approach:** We carried out a formative study to assess the challenges that WRoF face in getting reintegrated in the community. We interviewed local/religious leaders, teachers, village health teams, traditional birth attendants and five women repaired of OF. The five (5) women were aged between 19-80 years. Two of these women lived with their husbands, two were abandoned and the other one was a widow. Three of the women had children and two had lost their babies. Challenges that affected reintegration included: lack of community understanding of OF condition, WRoF being considered to be unfriendly, smelly and introverted; stigma/discrimination, lack of involvement and participation in community activities, and lack of love and care. Using these findings, community members identified a series of interventions necessary to help WRoF to reintegrate in the community. The interventions included: Identification of neighbors of WRoF who would visit them and their families to console, comfort and counsel them; making a contribution of food stuff or money to the family; encouraging WRoF to join village savings, and formation of digging clubs. These components were selected on the basis of simplicity, affordability, feasibility, acceptability, local ownership and being easy to implement. Implementation was done for a period of 8 weeks; thereafter a formal evaluation was conducted to assess the effect of the intervention on the reintegration experiences of WRoF.

**Intervention outcomes:** After eight weeks, women repaired of fistula reported to be happy, respected, able to speak boldly about the OF condition, more open and relaxed, and many of them reported that they had seen a change in their lives. Community members reported that they had understood the OF condition, and that they were ready to contribute to the fight to end OF, and to help women prevent OF by encouraging them to seek medical care while pregnant. Men were willing to be more involved in the lives of their women especially when pregnant.

**Lessons learned:** Community involvement is crucial in reintegrating women repaired of OF. Awareness of fistula as a medical condition can contribute to solving the social consequences associated with it. A participatory approach enhances ownership. Once communities are sensitized on the causes and challenges of OF, they become more responsive and are willing to help. This mitigates stigma related to OF.

**ABOUT CEHURD**

The Center for Health, Human Rights and Development (CEHURD) is an indigenous, non-profit, research and advocacy organization, whose vision is the realization of social justice in public health systems in East Africa region. Mission is to work towards an effective, equitable people centered public health system that ensures the full realization of the Right to health, promotes respect for human rights in health care policy and practice. CEHURD is pioneering the justifiability of the right to health in the East African Region. CEHURD is a non-profit company limited by guarantee under the Companies Act (Chapter 110 of Laws of Uganda) by the Ministry of Justice and Constitutional Affairs. CEHURD works through a comprehensive set of programs including Strategic Litigation, Community Empowerment, and Human Rights Documentation and Advocacy. CEHURD has also specifically developed a niche in the area of legal and policy research as well as publications. Further information about CEHURD can be obtained at: [http://www.cehurd.org](http://www.cehurd.org)
EMBRACING INFORMATION AND COMMUNICATION TECHNOLOGY TO IMPROVE PUBLIC HEALTH LABORATORY SERVICES DELIVERY IN UGANDA

ABOUT THE FELLOW

Michael Kasusse is a Health Information Specialist with a Master of Science in Information Science from Makerere University. Michael is a recipient of The Jacky McAleer Memorial Fellowship (University of Swansea, UK) and the Commonwealth Professional Fellowship (University of Sheffield, UK). He is an International Associate of Yale University Medical Library, USA.

Prior to joining the Fellowship, Michael worked as Medical librarian at Sir Albert Cook Library, Makerere University College of Health Sciences. He joined the Fellowship Program in February 2013 and was posted at the Central Public Health Laboratories (CPHL) in Kampala. CPHL coordinates laboratory services in Uganda on behalf of the Ministry of Health and provides stewardship to over 1,500 public laboratory facilities. While at CPHL, Michael pioneered the development of information technology solutions that provide accurate, timely, and secure information to guide public health action, including a digital library and website, eNotice Board, online survey data collection tool and a GIS spatial tool, among others. He has become a research fellow in public health informatics and in the long run, he intends to become an academician and a principal investigator (PI) of a national or regional public health informatics project. Michael says that, “My posting at CPHL has enabled me to acquire a strong network of national public health practitioners which has supported my hands-on experience of initiating pilot interventions that are capable of being replicated in other parts of Uganda. I attained competences of implementing programs at Ministry of Health, coordinating unpredictable activities and dealing with busy schedules of teammates.”

Key Fellowship responsibilities and accomplishments

**Develop the digital library and catalogue:** I designed, installed and tested a digital library using Greenstone 2.86 windows version software. This was after conducting a needs assessment that revealed a need for quick access and usage of selected information by laboratory persons and stakeholders from any part of the country. Using my expertise, I led the development of the website that is currently under management approval. The digital library and its resources including; policy documents, aggregate data, publications, flyers among others will be accessed through the approved CPHL website.

**Develop and produce the eNotice Board for CPHL:** I developed and produced 6 issues of the eNotice Board. This has boosted routine activity information collection, synthesis, storage, inventory and dissemination especially for field officers and external stakeholders. The eNotice Board has also served as an advocacy and information tool and presents a profile of activities within and without the laboratory sector.

**Conduct a baseline survey on the capacity of laboratory persons in using computers and other related technologies in Uganda:** I conducted a survey in 15 districts to ascertain the capacity of laboratory persons in using computers and other technologies in Uganda. Data were collected from 62 lab personnel working at HC IIIs, HC IVs and general hospitals. Findings show that only a small proportion (31%) of lab personnel access computers at work and of these, 48% read emails daily while 20% read emails on a weekly basis. These findings suggest that it is viable prepared in tables, graphs or maps for use by other stakeholders. This can save travel costs to and from the field if staffs at the health facilities are supported to use the ODK for submitting data or results in real-time using mobile phones.

**Develop and demonstrate the usage of an on-line survey data collection tool:** I customized the Open Data Kit (ODK) collect tool to transfer survey data from a remote health facility of Budondo Health Center (HC) IV in Jinja district to the ODK aggregate in real-time, using a mobile phone. These data can be validated, aggregated and presented in tables, graphs or maps for use by other stakeholders. This can save travel costs to and from the field if staffs at the health facilities are supported to use the ODK for submitting data or results in real-time using mobile phones.
and feasible to pilot informatics projects as strategies to develop skills for e-health landscape in laboratory services.

**Develop a training module for laboratory persons in the use of computers:** I developed a trainer’s guide for a computer course for the in-service training unit so as to equip laboratory personnel with the right ICT skills.

**Other achievements**
- I was part of a team that collected data in 8 health facilities in the districts of Gulu, Lira, Kaberamaido, Soroti, and Kumi to generate data necessary to guide quantification of laboratory supplies in order to inform the Global Fund planning process that was meant to include the laboratory sector.
- I chaired panels responsible for developing the mission, vision, conceptual framework and mapping of stakeholders during the development of the Laboratory Information Management System (LIMS) master plan.
- I served as the Secretary to the Biosafety and Biosecurity technical working group (TWG) of CPHL. I was also part of the committee that was tasked with monitoring the utilization of PIMA CD4 machines in 13 pilot lab facilities in the country.
- I identified indicators for the human resource thematic area of the CPHL M&E Plan, made final formatting of the Plan and followed it up with the Ministry of Health Director General to ensure that it was cleared for printing.
- I developed a course profile for the GIS for Health Science course, working closely with Department of Epidemiology and Biostatistics at MakSPH. Funding has been secured from partners to run this course beginning 2015.

**Communication, presentations & publications**

**a) Print media**

**b) Conference presentations**
During the course of the training, I made two oral presentations, one at a national and the other at an international conference, as shown below:
GSM technology to improve TAT for EID of birth defects results to health facilities in Uganda”. Oral presentation at the 6th International Conference on Birth Defects and Disabilities in the Developing World, Mactan Cebu, Philippines: November 10-13, 2013

c)  Manuscript submitted to a peer-reviewed journal:
Kasusse M, Tumwesigye NM, Aisu S, Matovu JK, Wanyenze R. Effectiveness of the credit-line approach in supporting the functioning of CD4 equipment in Northern Uganda. Submitted to the African Journal of Laboratory Medicine (Under review)

d)  Manuscript in preparation
“Real-time identification of incompetent laboratories under malaria and TB EQA schemes using GIS application in Jinja health region in Uganda” to be submitted to Health and Place journal

Programmatic Activity Summary

Using a customized geographical information system (GIS) application in identifying incompetent laboratories under the external quality assessment (EQA) scheme in Jinja health region

Background: Existing mechanisms do not provide for real-time identification of incompetent laboratories. Consequently, these laboratories continue to provide wrong test results to patients, which affect their ability to get the right treatment.

Objectives: To use a GIS application to identify incompetent laboratories (i.e. participating laboratories) that respond with results that are different from the results of the national reference laboratories, after an EQA survey) in real-time in Jinja health region in Uganda

Implementation approach: A GIS of ODK collect and Google earth was customized to link and visualize laboratory profile and EQA performance data. A cross-sectional study was conducted in 12 laboratories at HC IIVs and HC III in Jinja health region (composed of Iganga, Kaliro and Luuka districts). Data on laboratory profiles were collected using interviewer-administered questionnaires. Performance data was abstracted from laboratory records and transferred in real-time using mobile phones installed with an ODK collect application to a virtual server with predetermined grading that instantly attached a colour coding to the grade. Laboratories with less than 80% performance and those that submitted results beyond three weeks were identified as incompetent and were colored red. Server information was converted into a KML file that can be opened by Google earth application to provide visual presentations at a glance. Eight EQA officers were trained in how to open the KML file and assessed for skills acquisition in how to use the GIS application to identify incompetent laboratories using a self-administered questionnaire. Assessment scores were analysed using SPSS statistics 17.0 application.

Outcome: Using the GIS application, all officers were able to identify 5 out of 7 (71%) laboratories which were incompetent when conducting malaria tests and 4 out of 7 (57%) labs which were incompetent when conducting TB tests without seeking additional assistance. These findings suggest that GIS applications can be adequately used to identify incompetent laboratories in real time.

Policy implication: The Ministry of Health should adopt proven phone technologies that provide real-time transfer of data from remote districts, link EQA datasets, store and visualize EQA records at a glance so as to provide better record keeping, improved communication, while saving resources, time and energy.

About Central Public Health Laboratories (CPHL)
Central Public Health Laboratories (CPHL) is located on Plot 7/11 Buganda road and coordinates laboratory services in Uganda on behalf of Ministry of Health. CPHL’s vision is “Quality health laboratories services shall be available to all people in Uganda”; its mission is “To ensure sustainable health laboratory services to support the delivery of the Uganda National Minimum Health Care Package at all levels” and the goal is to “Establish coordinated Health laboratory services functioning according to national and international standards”. CPHL conducts its activities through 13 thematic areas including: Organization and Management, Laboratory services, Facilities and safety, Equipment and supplies, Human Resources, Laboratory Quality Management Systems, Laboratory Information Management systems, Research and Development, Community involvement, Partnerships, Regulatory and legal Framework, Monitoring and evaluation, and Finance and accountability. Currently, CPHL is a unit under National Disease Control (NDC) of the Ministry of Health, Uganda established in 1983 as a national reference laboratory to support the Epidemiological Surveillance Division (ESD) in disease surveillance and outbreak investigation. CPHL is transitioning into a semi-autonomous Directorate of the MOH called the National Health Laboratories Services (NHLS) in order to increase its impact of stewardship. Additional information about the CPHL can be obtained at: http://health.go.ug/mohweb/node/19
SCALING UP HIV SERVICE DELIVERY FOR KEY POPULATIONS AT REACH OUT MBUYA PARISH HIV/AIDS INITIATIVE

ABOUT THE FELLOW

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Executive Director, Reach out Mbuya Parish HIV/AIDS Initiative

Academic Mentor
Dr. Frank Kaharuza, MB ChB, MMed, PhD
Senior Research Fellow, MakSPH, Mulago

Take lead in expansion of HIV&AIDS services offered by ROM to key populations
- I conducted a needs assessment to identify the key populations living within and around Nakawa division, their health needs, and the existing service providers. As a follow-up to this, I created linkages with existing identified service providers to identify areas of collaboration so as to meet the health needs of the key populations.
- I led the establishment of three new ROM sites at Bweyogerere, Naguru and Kiwatule. Over the past year, 1,537 individuals received HIV counseling and testing services (HCT) at these sites. Of these, 219 (14%) tested HIV-positive; and 196 (89%) of them have been linked into HIV care.
- I supported activities in the new outreach sites through mobilization of FSWs to access moonlight (night) HCT services using the mobile van.

Provide technical support to the M&E department to design tools for capturing core data pertaining to the key populations
- I identified project indicators and designed tools to capture the required data. The tools designed included: clients' benefits tracking tool, skills building assessment tool, end of project evaluation tool, data quality assessment tool and reporting templates which were used in day-to-day activity implementation.
- I supported other M&E activities including participating in the ROM annual program evaluation, data quality assessments, reviewing ROM reports, file counting and continuous project monitoring for OVC. In addition, I created data entry screens to support the entry of data for all the women and children who had ever been enrolled into the PMTCT program which data is yet to be analyzed for publication. This enhanced my skills in data analysis and teamwork as well as use of the data

Key responsibilities and achievements
generated to write abstracts with staff, which were presented at various conferences.

**Provide technical support in building the capacity of the support staff in M&E and documenting project successes**
- I conducted a needs assessment and identified staff gaps in log-frame analysis and use of data for decision-making. To fill these gaps, I organized training for 18 staff and five volunteers in M&E. In addition, I provided ongoing support in gathering relevant data for set indicator targets, analyzing the reports and contributing ideas in M&E meetings that aided targeted implementation.
- I conducted field visits to beneficiary homes and identified and wrote success stories, which were captured in the donor reports and ROM newsletter. Two vulnerable families were identified in the process and supported with food and school fees.

**Support selected FSWs with vocational training and start-up of income generating activities**
- I conducted a baseline assessment for 86 FSWs and documented gaps in skills that still existed, including low education, financial skills and resource mobilization. Based on these findings, 19 FSWs were enrolled for vocational training (8 in hairdressing and 11 in tailoring) with support from the Roses of Mbuya Barclays Bank-supported training. Those who were trained in hairdressing were supported with starter kits and are engaged in personal business while those enrolled in tailoring are still undergoing training.
- I encouraged FSWs and other women of Kiwatule to form a Village Savings and Loans Association (VSLA) group. One group of 14 women has been formed.

**Build capacity of peer leaders to reach their key populations with prevention messages**
- I collaborated with FSWs to identify and select 22 FSWs for training in behavior change communication and community mobilization. In partnership with the Most-at-Risk Populations Initiative (MARPI), I conducted a five-days training for the 22 peer educators. The training was aimed at equipping the peers with messages on HIV prevention and mobilization skills so as to sensitize and mobilize fellow sex workers for HIV services. The trained peer educators have so far mobilized 360 FSW for HCT, linked HIV-positive FSWs to care and provided behavior change communication messages to their peers.

**Take lead in evaluating the mobile outreach project for the key populations**
- I identified the facilitators and barriers for linkage into care for FSW at ROM and spearheaded the inclusion of tailor-made services into the ROM budget based on the factors identified for linkage and retention in care.
- I created a database for all FSWs that had ever been enrolled in care at ROM. This helped to harmonize...
I initiated partnerships with Outreach Development Factors influencing retention into care among female sex workers; published in the New Vision on 6th /05 /2014.

b) Conference presentations

c) Manuscript submitted to a peer-reviewed journal

d) Manuscripts in preparation
- Outcomes of the mobile outreach model for improving access to HIV counseling and testing among female sex workers at a community-led organization in Uganda.
- Factors influencing retention into care among female sex workers in a community-based organization in Uganda.

In summary, I have grown in my leadership skills and strengthened my interpersonal and communication skills through working with different staffs at the host institution. I have also acquired skills in reviewing project plans, implementing changes in an organization and use of M&E information to implement needed changes. I have learnt to manage personal responsibilities as well as staff and resources. Above all I have greatly improved my skills in research, use of research findings for programming and scientific writing.

Innovations and creativity at the host institution
- I spearheaded the recognition and awarding of the long serving staffs at ROM (5 years and above) who were officially presented with medals by management.
- I initiated partnerships with the MARPs Network (a network of organizations that implement activities targeting key populations) to fund and facilitate staff training on the HIV/AIDS Prevention and Control Act.
- I took lead in holding discussions with WBS TV officials to air ROM successes in preparation for the World AIDS Day. ROM was granted airtime where the Medical services team shared experiences.
- I took lead in soliciting information, education and communication (IEC) materials for ROM through working with the SPEAR Project to provide materials that were relevant in passing on HIV prevention messages to ROM clients.
- I initiated partnerships with Outreach Development Foundation (ODF) to raise nutrition support for school-going orphans and vulnerable children (OVC) at ROM.
- I supported ten staff at ROM in writing and reviewing abstracts. All the 10 staffs were able to submit abstracts that were accepted for oral presentation at several national and regional conferences.

Communication, presentations & publications
a) Print media
- Emphasize mother-mentors programme; published in the Sunday Vision on 1/12/2013.
- Adopting tailor made HIV Interventions for female sex workers; published in the New Vision on 6th /05 /2014.

Other achievements
- I supported the HR department in performing key functions including: reviewing staff policies, reviewing the appraisal system, conducting interviews, staff audits and facilitating team building activities.
- I organized and participated in networking and partnership activities on behalf of ROM.
- I participated in the national launch of Option B+ in Kampala on behalf of ROM.
- I spearheaded ROM involvement in PEPFAR and CDC key populations and crane survey meetings that were geared at rationalization of services for key populations.
- I provided substantial support in organizing, chairing and taking minutes for Senior Management Team), CDC Cooperative Agreement and Annual General Meetings that were held at ROM and provided ideas that have promoted better service delivery for the ROM clients.
Factors influencing linkage and retention in HIV care among sex workers at Reach out Mbuya HIV/AIDS Initiative

Introduction: Up to four in ten sex workers are infected with HIV but fewer than 10% are enrolled in HIV care despite evidence that HIV treatment can reduce HIV transmission. This study describes the facilitators and barriers to linkage to and retention in HIV care following community-based HIV counseling and testing among female sex workers (FSWs) in Uganda.

Methods: This was a cross-sectional study conducted among FSWs who tested HIV positive at Reach Out Mbuya HIV/AIDS Initiative (ROM) in Uganda. Structured interviews were conducted with 144 FSWs, in-depth interviews with 29 FSWs and key informant interviews with five project staff and 11 peer educators. In addition; we conducted chart reviews and collected data on CD4 trends for FSWs (111) that had ever registered in care at ROM. Quantitative data were analyzed using STATA 13 while qualitative data were analyzed manually, coded and presented thematically. We used a parametric model (the weibull distribution) to investigate the association between retention in care and selected factors; adjusting for potential confounders.

Results: Of the 144 FSWs interviewed, 125 (86.8%) had been registered into care with 78% of these registered within one month of HIV diagnosis. Older FSWs (31 years and above) had 2 times higher odds of being registered within 1 month compared to those aged 18-30 years. FSWs who were married were more likely to be registered within one month compared to those who were not married. Of all the 111 FSWs ever registered in care at ROM; 95% were retained in care up to six months. FSWs with higher CD4 counts (351-500) at the point of enrollment were more likely to be retained in care compared to those enrolled with CD4 counts less than 200. However FSWs with higher CD4 counts (>200) at each visit had decreased odds of being retained in care compared to those who presented with CD4 counts less than 200. FSW receiving treatment from a static clinic were more likely to be retained in care compared to those receiving care from the mobile outreach clinics. The main facilitators for linkage to and retention in care were the good friendly services (polite and caring providers), strong follow up structures using peer educators, encouragement from peers, being a member of a savings group and the need to be healthy. Major barriers to linkage and retention included stigma (fearing to be seen by clients at the outreach HIV clinics), fear of drugs and myths related to ART, denial, lack of time, unawareness of the treatment centre, use of herbs, feeling healthy and financial constraints.

Conclusion: These data show high rates of linkage and retention to HIV care among FSWs. Quality services with good peer support mechanisms may enhance linkage to and retention in care. Interventions to address stigma and privacy concerns may further increase linkage and retention among FSWs.

Policy and public health implications
- Our data shows a need for the Ministry of Health to design policies and programs that focus on continuous counseling and education of the sex workers on HIV prevention and treatment as well as training health workers to offer specialized services.
- Our findings also call for a need to design programs that are friendly, faster, and closer to where the sex workers operate and engage the sex work community in delivery of services including peer educators, fellow sex workers and brothel owners.
- Finally, our data show the need for economic empowerment to be included in the comprehensive package of care for FSWs as this has been associated with improved health care.

About Reach out Mbuya Parish HIV/AIDS Initiative

Reach out Mbuya Parish HIV/AIDS Initiative (ROM), is a Community Faith-Based Non-Government Organization (NGO), founded in 2001 to provide holistic HIV/AIDS care to the urban poor persons infected and affected by HIV/AIDS (PHAs) within the service area of Mbuya. Its goal is to contribute to universal access to treatment, care, prevention, and social support in the communities served through the provision of comprehensive, community-based HIV and AIDS services. ROM operates in four service outlets of Mbuya, Bandana, Kinawataka in Kampala district and Kasaala in Luweero district. ROM uses the holistic model of care for the body, mind, family, and community needs of her clients through prevention, care and treatment and orphans and vulnerable children (OVC) support. Since its inception in 2001, ROM has reached more than 10,000 clients with HIV care, treatment and support services. Despite the remarkable impact, ROM was challenged by the increased numbers of a poor mobile population interspersed with key populations especially within Kinawataka and Acholi quarters. Additional information about Reach Out Mbuya can be obtained at: http://www.reachoutmbuya.org/
ENHANCING USE OF INFORMATION AND COMMUNICATIONS TECHNOLOGY TOOLS IN HEALTHCARE DELIVERY

ABOUT THE FELLOW

Vincent Micheal Kiberu holds a Master’s degree in Information Technology from Uganda Christian University, a Postgraduate Diploma in Computer Science and a Bachelor of Science (Mathematics & Computer Science) from Makerere University. Vincent is Oracle certified and has also attained advanced and advanced district health management information system (DHIS2) training and e-commerce. He has extensive experience in designing, implementation and evaluation of web-based information systems, administering huge electronic databases and training of users on e-learning platforms. Prior to joining the Fellowship, Vincent worked as the Head, Information Systems at Uganda Christian University and IT Manager at Posta Uganda. During his Fellowship training, he was posted at the Ministry of Health Resource Center (MoH-RC). The MoH-RC is mandated to develop an enabling environment for, and undertake activities to support effective and efficient management of information of the entire health sector. While at the MoH-RC, he contributed to enhancing use and performance of the DHIS2, data quality improvement, revision of the HMIS tools and publicizing MoH-RC’s work through publications. This enabled him to interface and interact with key stakeholders at various levels within the health sector. Through the fellowship, Vincent has acquired skills in strategic thinking and management, interpersonal and effective communication, mentorship, coaching and support supervision, as well as research skills. His aspiration is to work with a research institution to administer huge databases and to further his research skills. In his own words, this is what Vincent says of his Fellowship training: “Joining the fellowship program was DIVINE…and I have no regrets. It has led me into my career dream and transformed me from a mere ‘ICT techie’ to a prospective researcher in health informatics.”

Key responsibilities and achievements

Take lead in the revision of Health Management Information System (HMIS) Indicators and training of users.

a. I contributed to the writing of the HMIS Facilitators’ Guide that was used during the Training of Trainers (ToTs) workshop that was held at Jinja Nile Resort.
b. I worked as a rapporteur at a 5 days’ HMIS Training of Trainers’ workshop at Nile Resort hotel and contributed to the writing of the training report and the HMIS manual.

Take lead in HMIS data quality improvement:

I revised the district and health facility data quality assessment protocols that were used during the data quality assessment (DQA) and participated in conducting data verification and data quality audits in Nakaseke district. I wrote the data quality assessment report for Nakaseke district and contributed to the writing of the integrated report for the whole DQA exercise.

Provide HMIS technical support to District Health Teams (DHT) in Data Quality Assessment (DQA) and Data Demand and Use (DDU):

I mentored staff from the Securing Uganda’s Rights to Essential Medicines (SURE) project on the use of DHIS2. Trainees gained competencies in using pivot tables.

Take lead in the design, implementation and deployment of a software tool that will be used by the Ministry of Health as ICT Inventory and Projects Innovations Software:

I developed a concept note for the implementation of the ICT Inventory and Projects Innovations System and obtained functional and non-functional system requirements through interviewing key people in the Resource Center. I subsequently developed a system prototype based on the users’ requirements using entirely open source software. The system was tested using a few records after which one user was trained to manage the system.

Other achievements

a. I worked with the Resource Center-IT team in setting up an e-working environment for data entrants who captured data on the distribution of insecticide treated nets (LLITN).
b. I contributed to the development of the e-health strategic
plan, customization and revision of data elements and indicators based on the revised HMIS tools.

c. Together with the team in the Resource Center, we revised the Service Availability and Readiness Assessment (SARA) tool that was used by World Vision to collect data on maternal and newborn (MNB) indicators from health facilities in Kitgum district.

In summary, the fellowship has built my interpersonal and communication skills, strategic and analytical skills. I have networked and met important people within and outside the health sector. I have connected with international societies in e-Health and I have been able to learn and contribute to informatics forums. Besides, the fellowship has sharpened my statistical analysis and scientific writing skills.

**Communication, Presentations & Publications**

_a. Print media_

_i. Text messaging can improve HIV/ TB treatment._ Published in the Observer, 29th April, 2013.

_ii. Telemedicine faces many hurdles._ Published in the Observer, 11th June, 2013.

_iii. Time to marry technology and our healthcare system._ Published in the Observer 02nd May, 2013.

_b. Conference presentations_


_c. Journal article published in a peer-reviewed journal_

Programmatic Activity Summary

Piloting the Scale-up of District Health Management Information System-2 (DHIS2) Software to Health Center IVs in Luwero District

Background: Although DHIS2 was successfully scaled-up to district level in all the 112 districts of Uganda to help improve data turn-around as well as use of data for enhancing monitoring and evaluation of the sector, there has been no roll-out of DHIS2 to HCIVs. Health center IVs provide health care services and are sources of primary data that gets reported into the national HMIS system. This project aimed at piloting the rollout of DHIS2 to HCIVs in Luwero district.

Objectives: 1) Evaluate the human, equipment and utility needs that were essential for scaling-up DHIS2 at HCIVs. 2) Assess health workers’ knowledge, attitude and practices on data sharing and utilization. 3) Pilot DHIS2 in the three HCIVs in Luwero district.

Implementation Approach: The pilot study was conducted in three phases; the baseline assessment, roll-out and post-implementation. During the baseline study, an evaluation of the human, equipment and utility needs was conducted at the three health center IVs in Luwero district. In addition, we assessed health workers’ knowledge, attitude and practices on data sharing and utilization at health facilities using the self-administered questionnaires and key informant interviews. The roll-out phase was informed by results from the baseline study. Within this phase, the necessary equipment cited insufficient or lacking were procured to enable smooth implementation of the DHIS2 system. Such included; computer sets, printers, modems for internet connectivity and extension cables. Health workers responsible with data management at HCIVs were trained in how to use DHIS2, to enhance their skills in data sharing and utilization, data reporting and analysis using the electronic HMIS. A third phase evaluation was conducted after a period of three months to assess impact of the implementation. In addition, secondary data for timeliness in reporting rate were extracted from the DHIS2 system for the period February-April, 2014 and June-August, 2014 for the pre-and post-implementation period.

Findings/Outcome: We found that all the three HCIVs had a dedicated data management officer responsible for monthly data reporting. All health facilities were connected to the national electricity grid thereby creating a favorable environment for the rollout of the electronic HMIS. HCIVs were supplied with equipment such as computers, internet modems and stationary materials and also empowered with hand-on skills using DHIS2. Evaluation results indicated a remarkable improvement in the proportion of health workers having the right knowledge, attitudes and practices on data sharing and utilization after the rollout of DHIS2. Study results indicated; timeliness in reporting increased from 58% to 85% after the rollout of DHIS2. There was a significant increase in the knowledge of data sharing (68% to 96%, p<0.001) and utilization (45% to 95%, p<0.001) post-test. Similarly, the proportion of health workers (HWs) with a poor attitude towards data sharing significantly decreased (20% to 3%, p=0.04), as were those with a poor attitude towards utilization (18% to 4%, p<0.001). Ninety per cent of the health workers adhered to the set procedures in governing data access while 100% opted to use the electronic HMIS tool. Almost all (96%) HWs appreciated the fact that DHIS2 has lessened the burden for data sharing and utilization.

Lessons Learned & recommendation: We learnt that it is possible to scale-up DHIS2 to HCIVs and that scaling-up DHIS2 to this level can improve timeliness in reporting and facilitate data sharing and utilization at the primary points of data collection. Scaling-up DHIS2 to HCIVs calls for careful planning via the infrastructure needed, internet service provider to use, mode of training and staffing norms in the data management office adhered to.

Policy and public health Implication: This study will inform future scale-up of DHIS2 to HCIVs in Uganda and implementation approach in other countries that might need to rollout DHIS2.

About Ministry of Health Resource Center

The MOH-Resource Centre was established in the MoH under the Planning Department in the year 1999 with the mandate “to develop an enabling environment for, and undertake activities to support effective and efficient management of information of the entire health sector”, in collaboration with existing information services (e.g. local government and others). The RC Vision is to become a one stop center of excellence for management of health and health related data/information in the health sector while the Mission is to “Improve the quality of healthcare delivered to the Ugandan population by promoting the use of quality, accurate and timely health information by policy makers, planners, healthcare providers and other players in the national health system. The division is subdivided into three other units which include; National Health Data Bank, Documentations section (Library) and the Information, Communication Technology unit (ICT-Unit). The overall goal of the division is to establish and maintain a comprehensive source of routine health information for planning, Implementation and evaluation of the health sector. This can be achieved by undertaking the following functions: 1) Strengthen capacity for collection, analysis, use and dissemination of health and health related data at all levels 2) Coordinate the management of health and health related data/information at all levels 3) Strengthen documentation, storage and backup of health related data/information 4) Develop/ review policy guidelines and standards for data management at all levels 5) Monitor, supervise and evaluate the statistical development process. Further information about the work of the MoH Resource Center can be obtained at: http://health.go.ug/mohweb/node/76
STRENGTHENING THE MONITORING & EVALUATION SYSTEM FOR JINJA DISTRICT HEALTH DEPARTMENT

ABOUT THE FELLOW

Elizabeth Margret Asiimwe is a Monitoring and Evaluation (M&E) Specialist with a Master of Philosophy in Comparative and International Education from the University of Oslo, Norway. She also holds a Bachelor of Arts degree with Education from Makerere University and has attained professional training in M&E and program management. She has extensive experience in designing and implementing M&E systems for programs in national and international organisations. Prior to joining the Fellowship Program, Elizabeth worked with AMREF Uganda as an M&E Officer. She was attached to the Jinja District Health Department where she spearheaded the strengthening of the M&E system. Her major achievements at the host institution included; leading the development of the health department's Strategic Plan, its M&E plan and a health department website. Additionally, she has mentored the District Health Team (DHT) to analyze health data and write scientific papers that have been presented at national and international fora. Elizabeth’s most outstanding achievement was her delegation to coordinate health activities for a period of seven months. In this capacity she guided the district health team to refine the mission, vision, goals and core values of the health department. Elizabeth effectively represented the district in interactions with key stakeholders like the U.S. Centres for Disease Control and Prevention (CDC), Ministry of Health (MoH), implementing partners and the DHT. The long-term fellowship program has enhanced Elizabeth’s practical management and leadership capabilities. She is therefore leaving the program a transformed leader for public health programs. In her own words, this is what she had to say “On this fellowship ‘you are baked in a kiln that produces the strongest and finest brick’; I am leaving not only as an M&E expert but as a tested, experienced manager and transformative leader! I pride in this fellowship for this transformation.”

Key responsibilities and accomplishments

Lead the strengthening of a district M&E system in Jinja district health department

- I trained the district health team (DHT), health facility in-charge and records assistants in M&E, and led the development of the health department’s M&E plan and monitoring tools. I mentored the DHT in setting targets, analyzing data to inform their planning and improving the weaknesses identified. Some tools developed for M&E have been adopted by the district service commission for the monitoring visits at the health facilities.
- I supported the DHT in using the district league table to monitor periodic performance of the health facilities. As a result, an awards ceremony in recognition of the best performing health facilities and health workers was arranged in July 2014 in the district. This was presided over by the district leadership (technical and political).
- I supported the DHT to develop the health department’s five-year strategic plan (SP) to guide the health department activities. The SP was developed in a participatory manner and targets were set basing on the current district performance.

Provide technical support & build capacity of the district teams & partners to manage & operationalize the M&E plan & system

- I supported the DHT in using the district league table to monitor periodic performance of the health facilities. As a result, an awards ceremony in recognition of the best performing health facilities and health workers was arranged in July 2014 in the district. This was presided over by the district leadership (technical and political).

Take lead in identifying and conducting at least one operational research or other forms of research to generate information to support health planning

- I identified and conducted a research entitled; Factors influencing uptake of and retention on lifelong Antiretroviral Therapy among pregnant women newly diagnosed with HIV in
Jinja District. Study findings will help to improve uptake of and retention on lifelong ART among HIV-positive pregnant women. A summary of the findings is presented in the programmatic activity section below.

- I also supported the DHT and implementing partners (IPs) in conducting research in areas of strategic importance to the district health department. For instance, I was the supervision area team leader for a study entitled, “Knowledge, attitude & practice in the areas of HIV, Prevention of Mother to Child Transmission of HIV (PMTCT), Family planning (FP), Maternal and Child Health (MCH) and malaria”. This study was implemented by PACE in conjunction with the DHT. The study found that knowledge about HIV/AIDS spread and prevention was almost universal. However, while 43% had heard about FP, only 27% reported that they were currently using a FP method. These findings informed the design of FP-targeted messages for the District Health Education’s (DHE) department. My involvement in these studies helped me to sharpen my skills and increased my research experience.

Identify, analyze & use data from the strengthened M&E system for programming and writing manuscripts and abstracts: Using the data available in the district and from other secondary sources, I wrote eight abstracts and six of them were accepted for presentation; four at international and two at local (Ugandan) conferences. I also produced a manuscript entitled; “Implementation of Prevention of Mother-to-Child Transmission of HIV Program in Jinja District, Uganda: Successes, Missed Opportunities and Lessons Learned”. This manuscript is under review.

Provide technical support to the Medium-term fellows (for both Namutumba and Jinja district) in implementing their fellowship projects: I provided technical support and mentorship to two sets of Medium-term Fellows (MTFs) from Namutumba District and Mpumudde HCIV in their fellowship program. This involved reviewing their project proposals and guiding them in the implementation of the projects. I supported the Mpumudde fellows to use the Open MRS to generate reports and appointment lists for their HIV clinic. The two sets of fellows were among those that graduated in November 2013.

Build capacity of DHT members to write at least 3 papers and abstracts for disseminate in workshops and conferences: I built the capacity of DHT members in data analysis and writing of abstracts. As a result, DHT members wrote and presented six abstracts at national and international conferences.

Take part in the DHT meetings to advance and advocate for M&E for the health department: I actively took part in DHT meetings to advance the M&E agenda. As a result of my efforts, there is now money
allocated to fund M&E activities. Part of this funding has been used to facilitate the DHT members to attend and present abstracts at conferences.

Other achievements
- To enhance my leadership skills, the DHO delegated me the responsibility to coordinate health activities from May 2014 to November 2014. I successfully represented the office in administrative and management engagements with donors like CDC, the Ministry of Health, development partners and district leadership.
- I supported the AIDS Information Centre (AIC) in conducting M&E training for district personnel in 8 supported districts in Eastern Uganda.
- I supported the CEHURD long-term fellow in the review of her host institution’s strategic plan and guided her through the initial stages of the development of the M&E plan.
- I participated in the development and setting of targets for the Ministry of Health’s AIDS Control Program for the period 2015/16 – 2019/20 as a rapporteur for the eMTCT working group.
- I influenced the rewarding of the best performing individuals and facilities in the district health department which led to the first awards ceremony that was held in July 2014.
- I enhanced the culture of corporate branding; all health facilities and the district health office have the health department’s vision, mission and core values hanged on their walls for the health workers’ reminder of their responsibility.
- I coordinated the development of the district health department’s website (www.jinjahealthoffice.go.ug). Jinja District Health Department wanted a forum where it could share its work in real time. Today, the site presents information about the district health department, and through its Facebook link, people (especially the young) are able to interact with the health department on health issues.

Communication, presentations & publications
  a) Print media
    - Washing hands with soap and water sends away diseases. Opinion article. The New Vision, Wednesday April 24, 2013
    - Organizations should institute health and safety policies for their workers. Letter, published as letter of the day. Sunday Monitor, April 28, 2013.
  b) Conference presentations
    - Asiimwe EM et al. Predictors of uptake and retention on Lifelong Antiretroviral drugs by newly diagnosed HIV positive pregnant women in Jinja District.

Innovations and creativity at the host institution
- I influenced the rewarding of the best performing individuals and facilities in the district health department which led to the first awards ceremony that was held in July 2014.
- I enhanced the culture of corporate branding; all health facilities and the district health office have the health department’s vision, mission and core values hanged on their walls for the health workers’ reminder of their responsibility.
- I coordinated the development of the district health department’s website (www.jinjahealthoffice.go.ug). Jinja District Health Department wanted a forum where it could share its work in real time. Today, the site presents information about the district health department, and through its Facebook link, people (especially the young) are able to interact with the health department on health issues.

Programmatic Activity Summary
Factors influencing uptake of and retention on lifelong antiretroviral therapy among pregnant women newly diagnosed with HIV in Jinja District

Background: WHO recommends that all pregnant and lactating mothers be initiated on lifelong ART the moment they are diagnosed HIV positive to reduce mother-to-child (MTCT) transmission of HIV to below 5%. Uganda adopted these guidelines in 2012 and implementation in Jinja started in June 2013. This study aimed at assessing the factors influencing uptake of and retention on lifelong ART treatment among mothers newly diagnosed with HIV/AIDS in Jinja, to inform PMTCT program implementation in the district.

Methods: This was a cross-sectional study that employed both quantitative and qualitative research methods. It was conducted in two of the five health Sub-districts (One urban and one rural) and in 12 out of the 26 health facilities (HFs) accredited to offer ART in the district. Quantitative data were collected through a review of routine program data from maternity and ART records spanning a period of six months (June to December 2013). Data were analyzed for frequency distributions and cross tabulations; and Chi Square tests were conducted to test for any statistical differences between those retained and those not retained on lifelong ART across socio-demographic characteristics. Qualitative data analysis was done using SAS version 12. Qualitative data were gathered through key informant interviews with health workers and in-depth interviews with pregnant women newly diagnosed with HIV and analyzed manually to identify major themes.

Results: A total of 206 pregnant women who were newly diagnosed with HIV were enrolled into the study. All women were already initiated on Lifelong (LL) ART; majority (154, 75%) of who were initiated in the same month of diagnosis. Retention was characterized with intermittent adherence to monthly refill of drugs; only 135 (67%) adhered to their monthly appointments, 18% missed one to two and 15% missed three or more appointments. Those attending urban health units were more likely to be retained compared to those attending rural HFs (p=0.003), and so were those attending Private not for Profit (PNFP) as compared to government HFs (p = 0.0002). Mothers who had more than one child were more likely to be retained than those with one or no child (p=0.0001) and so were those above 24years old compared to younger ones (p= 0.04). However, there was no significant association between marital status and retention on LL ART (p=0.17). The prominent factors influencing uptake and retention were; disclosure to and spousal support, need to produce HIV-free babies, need for the pregnant women’s good health, intense counseling and support from health workers, easy access to health facilities, privacy of the maternity department and availability of drugs.

Conclusion: This study reveals that universal uptake of LL ART among pregnant women newly diagnosed with HIV is possible since all pregnant women were initiated on ART but it also shows inconsistent retention rates especially among younger women, women of low parity and those attending rural and public health facilities. These findings suggest that the district PMTCT program should establish strategies that will support retention of younger pregnant women and those residing in rural areas.

Program and public health implications: This study demonstrates that the younger pregnant women newly diagnosed with HIV are more likely not to adhere to lifelong ART, yet these are in the wake of their reproductive cycle. Therefore it is crucial that strategies to reach them as a special group be devised if the intended outcome of reducing MTCT through use of LL ART is to be realised. In addition, there is need for research to understand factors that hinder retention on LL ART among the young and low parity HIV-positive pregnant women.

About Jinja District Health Department

Jinja Health Department is found in Jinja district in Eastern Uganda, about 85 km east of Kampala, the capital and administrative city of Uganda. It has a total population of 501,300 inhabitants (UBOS 2012/13 population projections). The District health system is comprised of 5 health sub-districts, with 74 health centers; 54 are government owned and 20 privately owned. The District Health Department has an Administrative team referred to as the District Health Team (DHT), whose main roles are administrative as well as for technical support and oversight to the rest of the health staff in the district. The District health department has a vision of seeing "the people of Jinja District lead healthy and quality lives" and a mission that state that "Jinja District Health Sector strives to provide quality Curative, Preventive and Promotive health services based on national and local priorities to all people of Jinja District". These guide the operations and service delivery in the district. For more information about Jinja Health Department, please visit: www.jinjahealthoffice.go.ug
Rosette Maran Mugumya holds a Master’s Degree in Statistics (Biostatistics) from Hasselt University, Belgium; a certificate in Monitoring and Evaluation from Makerere University, Kampala; and a Bachelor’s Degree in Science (Statistics, Psychology) also from Makerere University, Kampala. Her areas of interest include research on Prevention of Mother-to-Child Transmission (PMTCT) of HIV, HIV counseling and testing among individuals and couples, and prevention among key populations. From January 2003 to August 2009, Rosette worked for the US Mission under the Centers for Disease Control and Prevention (CDC) in Uganda, first as a Data Management Assistant under the Home-based HIV/AIDS Care (HBAC) project and later as a Data Manager for the Prevention of Mother-to-Child Transmission (PMTCT) of HIV project in Tororo district. For her Fellowship training, Rosette was attached to the AIDS Control Program (ACP) under the Ministry of Health. The ACP is responsible for spearheading HIV/AIDS control activities in the health sector. Rosette believes that the fellowship program was a huge stepping-stone in enhancing her goal to become an accomplished Public Health Researcher. In her own words, Rosette says “the activities that I was involved in during the apprenticeship period (such as proposal writing and the several assessments and support supervisions) could never have been found anywhere else. The exposure I got at the Ministry of Health AIDS Control Program was an excellent opportunity for me to grow both personally and professionally. The programmatic activity I carried out exposed me to a new software, i.e., OpenMRS, which I have mastered and can use later in my career. I also got an opportunity to train in the District Health Information System (DHIS) because of my being placed at the Ministry of Health”.

**Key responsibilities and accomplishments**

**Take lead in conducting a sero-behavioral survey among truckers along the major transport corridors in Uganda, as a Principal Investigator:** I took lead in writing the technical and financial proposal which I submitted to the Higher Degrees, Research and Ethical Committee for review and approval. The proposal was is now with CDC for final review and approval before data collection starts.

**Take lead in preparation of a manuscript from the 2011 Uganda AIDS Indicator Survey (UAIS) data:** I have written one manuscript from the 2011 Uganda AIDS Indicator Survey (UAIS) data entitled “HIV/AIDS Stigma: an Impediment to uptake of HIV services in Uganda; Results of the Uganda Indicator Survey 2011”. I expect to complete and submit this manuscript to a journal by December 31st 2014.

**Other achievements**

- I participated in preparing the antenatal care (ANC) Surveillance Research Protocol. Together with other M&E unit members, we organized a 5-days workshop in which I was a facilitator for the data management and analysis section of the protocol. As a facilitator, I compiled reviews from all members and used them to come up with a revised section. The surveillance data have been collected and data analysis is ongoing.
- I was involved in the Data Quality Assessment of the treatment, quality of care, and PMTCT data reported by CDC Implementing Partners at selected sites in Uganda. I was assigned to be the assessor three districts (Mbarara, Masaka and Kalungu) on behalf of the Ministry of Health. I generated a report from this activity which depicted poor data capture and poor management systems in most of the health facilities that I assessed. The findings of this exercise helped to inform my choice of the programmatic activity to strengthen PMTCT data capture management and reporting at Muko H/C IV in Kabale district.
- I was involved in the national review of PMTCT Option B+ rollout and implementation where I participated as a
reviewer in Arua, Masindi and Hoima districts on behalf of the Ministry of Health. Together with other reviewers, we recommended that this activity be carried out at the national level, which was indeed carried out shortly after the review.

- I was part of the National Assessment of Health Centre IIs for comprehensive HIV care including ART as an assessor in in Gulu, Kitgum, Lamwo and Amuru districts. Other assessors and I wrote a report indicating that 10 of the 35 health centres we assessed met the requirements for comprehensive HIV care including ART. Discussions are underway to accredit all H/C IIs that met the accreditation requirements for comprehensive HIV care.

- I was part of a team that organized a 5-day workshop to support the development of the National HIV/AIDS M&E Framework HIV/AIDS. In this workshop, I served as the rapporteur and produced a workshop report which informed the revision of the draft framework to generate a final National HIV/AIDS M&E Framework.

In summary, my involvement in the above-mentioned activities has helped me to improve my written and oral communication skills and I was able to enhance my data analysis skills as I analyzed the 2011 AIDS indicator survey data. I have also been able to enhance my M&E skills through the PMTCT rollout review. In addition, I have enhanced my mentoring and coaching skills from the eMTCT support supervision visits that I carried out during the training period. Finally, I was able to update my information and communication technology skills as I wrote and submitted various reports and presentations at different forums.

**Innovations and creativity at the host institution:**
During my programmatic activity project of strengthening PMTCT data capture, management and reporting at Muko H/C IV, I went ahead to automate two monthly HMIS reports - HMIS 105 and HMIS 009a – such that at a click of a button, a report is generated and ready for printing. This made the reports compilation less tedious.

**Training and capacity building conducted at the host institution:**
I trained 7 staff of Muko H/C IV in PMTCT data collection procedures using the national PMTCT codes and the national reporting indicators. These 7 staffs were also briefly exposed to the OpenMRS data capture and management software. Two of the seven were then provided with additional hands-on instructions on how to enter, retrieve, edit, and analyze data entered into OpenMRS as well as instructed on how to conduct validation of data captured in the PMTCT registers. More so, the two staffs were trained on how to automatically generate monthly reports. This was part of my programmatic activity (presented in detail below).

**Communication, presentations & publications**

a) **Print/electronic media**

i. “Early HIV Counseling and Testing is the only way to...”

Fellow (first on the right) handing over a computer to the staff and management of Muko H/C IV.


iii. “Government should ban shisha smoking” published in the Observer on June 12th-13th 2013.


b) Conference presentations


c) Manuscript submitted to a peer-reviewed journal


d) Manuscript in preparation


Programmatic Activity Summary

**Strengthening PMTCT data capture, management and reporting at MUKO H/C IV**

**Background:** A review of the PMTCT data at Muko H/C IV for the months of June, August, July and November 2013 showed inconsistencies among the data captured in the registers and what was finally reported. It was thus difficult to monitor progress of the PMTCT program. The project intended to strengthen PMTCT data capture, management, and reporting at the health facility for proper M&E of the PMTCT Program.

**Objectives:** The specific objectives of the project were: (a) To train staff at Muko HC IV in PMTCT data collection methods by use of the national PMTCT codes, (b) To design and implement an electronic data capture and management system for PMTCT, (c) To design and implement a records filing and storage system for PMTCT records and (d) To train the records staff at Muko HC IV in generation of electronic monthly reports, all by July 2014.

**Implementation Approach:** A data team of 7 members was formed and trained in PMTCT data collection procedures and exposed to OpenMRS. Two of the seven staff – Records Officers – were trained on how to enter, retrieve, edit, and analyze data entered into OpenMRS as well as instructed on how to conduct validation of data captured in the PMTCT registers. Data were then entered daily and at the end of the month, an electronic monthly report generated and submitted to the district.

**Outcomes:** Over 2000 records from the PMTCT registers from May 2014 to November 2014 have been entered into the computer using OpenMRS. Every end of month, two electronic reports, i.e., HMIS 105 and HMIS 009a, are generated and sent to the district to be fed into the national DHIS2 database. This has made the reporting of PMTCT data less tedious. All entries are validated automatically generated from the system.

**Lessons Learned & recommendations:** It is possible to operate a simple database in a rural health facility using simple software like OpenMRS as long as one has a computer and a reliable power supply. OpenMRS should be introduced in at least all H/C IVs in the country; this will go a long way in solving the problem of inaccurate data that exists in the Uganda health system.

**About the STD/AIDS Control Program – Ministry of Health**

The STD/AIDS Control Program of the Ministry of Health was the first institution in the country to spearhead and undertake HIV/AIDS control following detection of the outbreak of the epidemic in 1986. Over the years, its activities and strategies have evolved as more knowledge about the epidemic and its control has come to light. With the decentralization of HIV/AIDS control activities during the 1990s, and the adoption of the multi-sectoral approach in 1991, the role and activities of the Program changed. Currently, the Program is responsible for spearheading HIV/AIDS control in the health sector. Within the ACP, there is a strategic information unit which is mandated to ensure collection of high quality data on HIV/AIDS to monitor the health sector response to HIV/AIDS; promoting data use at all levels to inform HIV programming by producing and disseminating program implementation reports. This is the unit where I was attached as a Fellow. Further information about the AIDS Control Program can be obtained at: [http://health.go.ug/mohweb/node/10](http://health.go.ug/mohweb/node/10)
My participation in the Fellowship training has enabled me to attain skills in
Capacity Building to
coordinate the UNFPA-funded sexual and reproductive
health program: I took lead and coordinated the UNFPA-funded
SRH program and there was a remarkable improvement in focus, outputs attained and in numbers reached with SRH and HIV services. Specifically, I was able to achieve the following outputs: development of quarterly work plans for SRH programs, development of implementation guidelines with indicators for the integration of SRH and HIV/AIDS; providing technical support in consolidating quarterly SRH progress reports and organizing coordination meetings for an assessment of integrated SRH and HIV/AIDS service provision in five districts (Kotido, Moroto, Kaabong, Yumbe and Kanungu). An assessment report has been submitted to UNFPA.

Provide technical support in resource mobilization: I was a member of the technical team that developed 4 proposals for resource mobilization. Of these, 1 was funded (Capacity Building to Scale up Screening for Cervical Cancer in Uganda - funded to the tune of $ 50,000) while the other three are still under review.

Provide technical support in capacity building for peer educators: I coordinated and provided technical support in the training of peer educators for sex workers (SWs).

Provide technical support in the documentation of AIC best practices: I provided technical support in the development of the best practices framework for the AIC using guidance from UNFPA. I took lead in formulating the best practices guidelines and guidance notes for staff, and supported AIC staff to document the work experiences, best practices, challenges and recommendations in form of reports and conference abstracts. I developed an abstract format, which was sent to the regional offices for reference and provided technical support to staff to write and present five abstracts at national conferences.

Engage in management-related tasks: I reviewed the Operational Manual for the Board of Trustees, the Human Resources Manual and staff appraisal tools. I identified areas for improvement and discussed them with senior management for appropriate action. I was also part of the interview panel that vetted candidates for the AIC Human Resources Office including for the position of Manager for Kampala region. I appraised staff at different levels for better performance. I have participated in management meetings, including one where I presented a proposal and study findings of my programmatic activity. I represented AIC in over 15 SRH specific meetings where I made presentations on SRH activities, shared AIC experiences and advocated for more funding for activities under the mandate of AIC.

In fulfilling my terms of reference, I was able to attain competencies in program implementation, advocacy, lobbying, monitoring and
evaluation to assess progress and impact of interventions networking, mentorship, analytical writing for scientific and none scientific audiences, coaching, information use for leadership, strategic thinking and management skills that were fundamental to my carrier development and achievement of my personal goal.

**Other achievements**

- I was part of the procurement committee for selecting consultants for various assignments and reviewed their proposals and reports.
- I reviewed AIC newsletter for the 3rd and 4th quarters and made suggestions for improvement.
- I represented AIC at the National Prevention Committee meetings in which we reviewed proposals and reports to inform policy and programming in Uganda.
- I initiated and coordinated the e-MTCT at AIC level as part of the national launch for the e-MTCT program spearheaded by the First Lady.

**Communication, presentations & publications**

*a) Print/electronic media*

I wrote and published nine newspaper articles that helped to influence policy and practice in Uganda. The nine articles are:

- “Involve community leaders to scale up immunization”, published in the Daily Monitor on April 19th, 2013.
- “All mothers need support to breast feed their children”, published in the Daily Monitor on August 5th, 2013.
- “The cruel sexual buses by rapists can be minimized”, published in the New Vision in April, 2014.

*b) Conference presentations*

During the course of the training, I made five presentations at national conferences, four of which were oral while one was a poster presentation, as summarized below.


**The fellow (Sharon) in dark blue dress making a poster presentation**
To assess the process of implementation of the MakSPH-CDC Fellowship Program,

The model was generally implemented as planned except that there was no launch of the model for integration in Mubende District. The main challenges encountered during the implementation of the model were staffing, system, and service user-related. Integration was cherished for providing opportunities for health education, resource saving, and service utilization.

Policy and public health implications: Study findings highlight the need to increase the number of health workers to match the needs at health facilities and ensuring availability of adequate supplies as prerequisites for integration.

About AIDS Information Centre: AIDS Information Centre-Uganda (AIC) is a Non-Governmental Organization established in 1990 to provide HIV counseling and testing services. Today AIC contributes to over 300,000 annually of the total number of people counseled and tested for HIV in Uganda. AIC has since evolved and provides a wide range of HIV prevention, care, support, and SRH services. The organization offers its services through 8 regional centers across the country and currently operates in 53 districts. AIC employs over 100 staff of different academic backgrounds. Most of the senior members of staff have attained qualifications at a master’s level. While at AIC, the fellow was hosted in the programs and planning section which is comprised of Care and treatment; Prevention; Capacity building; and monitoring and evaluation departments. The section is headed by the Director of Programs and Planning who was the primary host mentor. Additional information about AIC can be obtained at: http://www.aicug.org

Programmatic Activity Summary

Evaluation of the process of Implementation of Sexual and Reproductive Health, HIV/AIDS and Maternal Health Integration Model in Katakwi and Mubende Districts

Introduction: Integration of sexual and reproductive health (SRH), HIV/AIDS and maternal health (MH) services is a critical strategy to confront the HIV/AIDS epidemic, high maternal mortality and the unmet need for contraception. In 2011, AIDS Information Centre in partnership with the Ministry of Health (MoH) developed an SRH, HIV/AIDS and MH integration model. This study sought to document the implementation process of this model in Katakwi and Mubende districts.

Objectives: To assess the process of implementation of the model by district hospitals and health center level IV; identify the services provided in relation to what was recommended in the model; establish challenges encountered and lessons learnt in the process of implementing the integrated HIV, antenatal (ANC) and postnatal care (PNC) services.

Implementation approach: The implementation of the model started with the launch of the integrated SRH, HIV/AIDS and MH services by the district health teams (DHT) and implementing partners. To facilitate full implementation, the DHT and MoH set up systems to address gaps (e.g. staffing, supplies, allocation of rooms, etc.) identified. Districts were tasked with: (i) orienting all stakeholders including district and Sub-County leaders on integration guidelines, (ii) conducting training for technical health personnel in integrated service provision, (iii) mapping out partners and identify space, and (iv) setting up systems for integration of services, develop IEC materials, mobilize and sensitize communities. Service integration was planned to take place at health center (HC) IlIs, HC IVs and district referral hospitals. The implementation process also provided for ongoing support supervision, mentorship, monitoring and evaluation as well as program implementation review by the district administration. The purpose of the model for integration was to increase access and uptake of SRH, HIV and MH services among the general population in districts of Katakwi and Mubende.

Data collection: This was a qualitative study. Data were collected using focus group discussions (FGDs) and 21 key informant interviews. Ten FGDs were conducted with 6-10 service users to assess knowledge of the existence of integrated services and find out the consistency in services provision on different days of the week. During the FGDs, participants were asked whether they received any health education received at ANC and PNC, what HIV services they received, referrals made in case of positive mothers and infants exposed to HIV during PNC, challenges encountered as well as lessons learnt in receiving integrated HIV, ANC and PNC services. FGD participants were also asked about suggestions for improving the provision of integrated services particularly HIV, ANC and PNC services. The KIs were conducted with selected 21 (11 men and 10 females) district health managers and health workers to explore to explore the process for implementation, challenges and lessons learnt during process of implementation. Health workers were also asked to talk about the services provided in relation to those spelt out in the model, challenges and lessons learnt during integrated service provision. All interviews were audio-recorded with consent from the participants.

Intervention outcomes: The model was generally implemented as planned, except that there was no launch conducted in Mubende district. Assessment and provision of medical supplies and equipment to health facilities was carried out by MoH and development partners. For this evaluation, integration was considered to have taken place if mothers attending ANC and PNC were provided with HIV services. From the study findings, ANC and PNC clients were provided with HIV services as expected, including health education on HIV/AIDS, HIV counseling and testing, and if HIV-positive; anti-retroviral therapy; or referred to health facilities where these services were provided. The main challenges reported included fewer staffs at the facility, gaps in knowledge of service providers, structural challenges, shortage of critical supplies, high expectations of mothers and informal charges for services and supplies.

Lessons learnt: Integration provides an opportunity to discuss various issues during health education, eases provision of health services and improves demand and uptake of services.

In conclusion, the model for the integration of SRH and HIV/AIDS services was generally implemented as planned except for the launch which was not done in Mubende District. The main challenges encountered during the implementation of the model were staff, system, and service user-related. Integration was cherished for providing opportunities for health education, resource saving, and service utilization.

**Policy and Public Health Implications:**

- Study findings highlight the need to increase the number of health workers to match the needs at health facilities and ensuring availability of adequate supplies as prerequisites for integration.

**About AIDS Information Centre:**

AIDS Information Centre-Uganda (AIC) is a Non-Governmental Organization established in 1990 to provide HIV counseling and testing services. Today AIC contributes to over 300,000 annually of the total number of people counseled and tested for HIV in Uganda. AIC has since evolved and provides a wide range of HIV prevention, care, support and SRH services. The organization offers its services through 8 regional centers across the country and currently operates in 53 districts. AIC employs over 100 staff of different academic backgrounds. Most of the senior members of staff have attained qualifications at a master’s level. While at AIC, the fellow was hosted in the programs and planning section which is comprised of Care and treatment, Prevention, Capacity building, and monitoring and evaluation departments. The section is headed by the Director of Programs and Planning who was the primary host mentor. Additional information about AIC can be obtained at: [http://www.aicug.org](http://www.aicug.org)
SUPPORTING KNOWLEDGE TRANSLATION IN EIGHT LOW AND MIDDLE INCOME COUNTRIES

ABOUT THE FELLOW

David Roger Walugembe holds a Master of Public Health from the James P Grant School of Public Health, BRAC University, Bangladesh and a Bachelor’s degree in Library and Information Science from Makerere University, Uganda. He is passionate about research dissemination and translation of knowledge into policy and practice as an avenue for strengthening health systems. Previously, David worked as a Communications Specialist with the University Research Co.–Strengthening Uganda’s Systems for Treating HIV/AIDS Nationally (URC-SUSTAIN) Project, Communications/Public Relations Officer with Uganda Virus Research Institute-International AIDS Vaccine Initiative (UVRI-IAVI) HIV Vaccine Programme, and Information Scientist with the Ministry of Public Service. During his Fellowship training, David was hosted by Makerere University School of Public Health under the Department of Health Policy Planning and Management (MakSPH-HPPM) specifically the Knowledge Translation Network (KTNET) Africa Project. This Network is composed of eight research coalitions spread across eight sub-Saharan African countries funded by the Netherlands Organisation for Scientific Research (NWO). The objective of KTNET Africa is to maximize the impact of research evidence generated on health systems policy and practice in low and middle-income countries (LMICs). David participated in and supported the establishment of the KTNET project. The invaluable experience of being a fellow greatly enhanced his career ambition of becoming an expert at creating linkages and facilitating the transfer of knowledge between researchers and evidence users. It equipped him with hands on negotiation, project management, scientific writing, monitoring and evaluation, strategic thinking and leadership, networking, coaching and mentoring, and the ability to multi-task. His interpersonal and effective communication skills as well as the use of information communication technologies were also greatly enhanced.

Key responsibilities and accomplishments

Lead and or participate in the planning and management of KTNET project activities: I led, participated and supported several activities that have facilitated the establishment of KTNET. These included the development of the three-year project work plan and implementation plan, undertaking a stakeholder mapping exercise, and the development of online platforms including a project website and other social media outlets. These activities have guided the implementation of the project activities, and engagement of coalition partners and other external audiences. In addition the online platforms have facilitated dissemination of the project and partner outputs including policy briefs, blogs and articles. The execution of these activities greatly contributed to my project planning, management, monitoring and evaluation skills.

Develop capacity of stakeholders to utilize research findings in policymaking and strategic planning processes: I coached and mentored coalition partners, researchers, media, students and team members on knowledge translation. For example, I coached and mentored researchers and members of the media fraternity from Burundi, Democratic Republic of Congo, Ghana, Ethiopia and Rwanda on the dissemination of health research findings. I facilitated a session entitled; “Introduction to health communication, sources of evidence and communicating research...”
to the media” during the training workshop for coalition partners. I also facilitated sessions for the Bachelor of Environmental Health students at MakSPH, Health Systems fellows in Kasangati and Postgraduate medical students. Specifically, I facilitated sessions on “effective communication of research to the media, communication skills, advocacy and evidence dissemination”. The experience of facilitating these sessions greatly enhanced my coaching, mentoring and communication skills.

Develop a framework for monitoring and evaluating the effect of KT activities within the Network: I coordinated and supported the KTNET secretariat team to undertake a baseline survey including: conducting a stakeholder mapping, stakeholder analysis and KT capacity assessment. With regard to the KT capacity assessment, I developed the protocol and presented it before the higher degrees and research ethics committee (HDREC) of MakSPH. I pretested and refined the tools, trained contact persons who supported the data collection process across the 8 coalitions and supervised data collection. Additionally, I worked with team members to develop and submit the monitoring and evaluation protocol as well as a manuscript that was recently submitted to the journal of Implementation Science. These accomplishments provided me with hands on project monitoring and implementation skills. These activities have enhanced my strategic thinking, negotiation, leadership and management skills.

Communication, presentations & publications

i. Print/online media

Newspaper articles
i. “To improve access to medicines in Uganda, we must play as a team” Daily Monitor (Thursday, October 17th, 2013)
ii. “Create a supportive environment to end teenage pregnancy in Uganda” New Vision (Thursday, October 17th 2013)
iii. “Uganda should take practical measures to check population” Daily Monitor (Friday, July 12th 2013)
iv. “Recruit more health workers and provide conducive work environment” Daily Monitor, (Tuesday, July 2nd 2013)

KT focused blog articles
i. What Makes A Good Press Release?
ii. Community Engagement (CE) What Is It And Why Is It Important?
iii. Evidence Informed Decision Making: What Are Your Sources of Evidence?
iv. Increased Emphasis On The Use of Evidence From Systematic Review
v. What Capacities Are Needed To Successfully Support Knowledge Translation (KT)?

b) Conference presentations


c) Manuscripts submitted to peer-reviewed journals

d) Manuscripts in preparation
- Do media have the capacity to influence policy making? Findings from a multi country cross sectional survey in sub Saharan Africa.
- Engaging media in knowledge translation: experiences in packaging and communicating research evidence
- Packaging research evidence for implementing partners: a researcher’s experience.

Programmatic Activity Summary

Assessing Knowledge Translation Capacity of Eight Research Coalitions Coordinated by the Knowledge Translation Network (KTNET) Africa

Introduction: The capacity of researchers and evidence users to identify, access, assess the value of, interpret, and apply to contexts as well as utilize or support the utilization of research findings for evidence-based policy making is critical to the successful transfer and exchange of knowledge. Against this background, the Knowledge Translation Network (KTNET) Africa undertook a Knowledge Translation (KT) capacity assessment for each of its eight coalitions.

Objectives: The overall objective of the KT capacity assessment was to assess the generative, disseminative, absorptive and adaptive capacities needed by coalition researchers and their stakeholders in order to successfully engage in knowledge translation.

Methods: This was a multi-country cross-section survey using both quantitative and qualitative tools. The study was conducted across eight research coalitions spread across eight countries including: Uganda, Rwanda, Senegal, Ghana, Ethiopia, Burundi, DR Congo and South Africa. Study participants included both researchers who generate health systems evidence and research users such as; policy makers, civil society organizations, health care service providers, media and community representatives. These respondents were purposively selected based on the results of a stakeholder analysis exercise that preceded this study.

Results: Preliminary data analysis for 5 out of 8 coalitions revealed that policy makers (60%), researchers (89%), and media practitioners (64%) perceived their capacity to evaluate the quality of the research evidence as adequate. On the other hand, 65% of the researchers reported their capacity to package and disseminate evidence as moderate, 72% of the policy makers occasionally referred to the evidence while 33% media
practitioners rarely used it in the process of compiling, editing and or disseminating news. Most policy makers (68%) rated the knowledge of researchers about the research priorities and policy making processes as limited.

**Conclusion:** The capacity of both researchers and research users to generate, package, assess the quality of research evidence and utilize it to inform health policy making processes needs to be strengthened.

**Policy and public health implications:** Findings from this assessment provide a baseline for existing knowledge translation capacity for both researchers and research users. Additionally they provide a foundation for supporting the training of researchers and their stakeholders for effective KT in their respective countries.

**About Makerere University School of Public Health-Department of Health Policy Planning and Management (MakSPH-HPPM)**

Makerere University School of Public Health specifically the Department of Health Policy Planning and Management (MakSPH-HPPM) has expertise in health systems including health financing, health economics, service delivery and vast research experience in human resources for health, governance, health management information systems, knowledge translation and medical supplies and technologies. MakSPH-HPPM collaborates with the Ugandan Ministry of Health and with district, municipal and city local governments, international agencies and non-governmental organizations (NGOs) in supporting the planning and implementation of health programs. Recently, MakSPH-HPPM won a grant to establish a health system’s-related Knowledge Translation Network (KTNET Africa). The Network comprises of eight research coalitions funded by the Netherlands Organization for Scientific Research (NWO). These coalitions are spread across 8 sub-Saharan Africa countries including; Rwanda, Burundi, DR Congo, Uganda, Ethiopia, Ghana, Senegal, and South Africa. Further information about KTNET Africa can be obtained at: [http://www.ktnetafrica.net](http://www.ktnetafrica.net)
Dr. Owor Michael holds a Bachelor’s degree in Medicine and Surgery (MBChB) from Mbarara University of Science and Technology and a Master’s degree in Public Health Methodology (MPHM), specializing in Epidemiology & Biostatistics, from Université Libre de Bruxelles (ULB) in Belgium. Prior to joining the Long-term Fellowship, Michael attended the Medium-term Fellowship program. During his Fellowship training, Michael was posted to Baylor Uganda, an indigenous not-for-profit organization involved in providing family-centered pediatric and adolescent HIV/AIDS services in Uganda. While at Baylor, Michael was placed under the ‘Saving Mothers Giving Life (SMGL)’ project in line with his interest in Maternal, Newborn and Child Health. SMGL is a proof of concept initiative aiming at reducing current maternal and newborn deaths by 50% in the three project districts of Kabarole, Kamwenge and Kyenjojo in western Uganda. This project has 2 key objectives: (i) to increase access to and utilization of quality comprehensive obstetric care, and (ii) to increase access to and utilization of quality care for well and sick newborn babies. During the 2-year posting at Baylor Uganda, Michael developed a draft postnatal care strategy hinged on following mothers after discharge from facilities using Village Health Teams (VHTs) and promoting beneficial newborn care practices in the communities among mothers who have recently delivered (within three months). The strategy aims at encouraging mothers to return for postnatal checkups. During the 2-year training, Michael has had a rich experience in designing, implementing, and operationalizing projects in communities and gained substantial experience in written and oral communication, with a particular focus on communication of research findings. In his own words, Michael summarizes his experiences on the Fellowship program in the following words, “This has been a vigorous mind-blowing experience: I have had practical experience in strategy development especially where multiple partners are required, designing and implementing research activities aimed at informing program design in Maternal Child Health spheres and also writing grant proposals. I am not the same as before the fellowship!”

Key responsibilities and accomplishments

**Take lead in development of a post-natal care (PNC) service improvement strategy:** I took lead in the drafting of a postnatal care strategy, aligning it to the National Health Strategy and obtaining consensus from the three project districts. The strategy is hinged on using VHTs to follow up mothers on day 1, 3 and 6 after discharge to promote newborn care practices and also encourage early return to the health facilities for PNC care such as immunization, cervical cancer screening, and breast cancer screening, among others. The strategy is complete but not yet implemented.

**Implement, monitor and evaluate the PNC strategy:** The strategy is still in its draft form and awaits revision, based on baseline, process and end line evaluation findings.

**Pilot interventions in PNC aspects of Saving Mothers Giving Life (SMGL) project to improve newborn survival:** I piloted interventions in the postnatal care aspects of the SMGL project as part of my programmatic activity to inform the implementation of the PNC strategy.

In summary, my accomplishments with regard to my terms of reference have enhanced my skills in strategy development processes, negotiating, engaging multiple stakeholders and also
documentation processes. I have also been able to design, implement and evaluate community interventions to inform strategies or program designs.

Other achievements
- I conducted one-on-one mentorship to VHTs and health facility staff in performing surveillance activities of women of reproductive age, maternal deaths, and newborn deaths.
- I took lead in coordinating training of VHTs in newborn health in Bukuuku and Kibito sub-county.
- I took lead in designing work plans and budgets for approved projects; for example, work plans and budgets for my programmatic activity project.
- I played a key role in revising, piloting tools, collecting data and supervising data collection teams for the Health Facility Assessments (HFA) study.

Communication, presentations & publications

a) Print media

“Thousands could be saved with Rotavirus vaccination”. Published in the New Vision online version, May 15, 2013.

b) Conference presentations


c) Manuscripts submitted to peer-reviewed journals


d) Manuscripts in preparation:

i. Opportunities and Challenges in Uptake of Beneficial Newborn Care Practices among Mothers in the Rwenzori Region: a Process Evaluation

ii. Determinants of Use of Natural and Artificial Family Planning Methods during the Extended Post-partum Period among Women of Reproductive Age in Eastern Uganda: a Cross-Sectional Study

iii. District Performance within the Early Infant Diagnosis Cascade in the Rwenzori Region: a Cohort Analysis.
Programmatic Activity Summary

Use of Village Health Teams in promoting new born care practices among newly delivered mothers in the Rwenzori region: a process evaluation

Introduction: Newborn deaths are still high despite the fact that existing community structures (VHTs) have the propensity to contribute to their reduction. We piloted promotion of selected newborn care practices among newborn mothers in the Rwenzori region using VHTs.

Objectives: (i) To assess baseline knowledge, attitudes and practices of Newborn Care practices among VHTs in the Rwenzori region, and (ii) To document implementation processes and intermediate results of a community-based intervention aimed at using VHTs to promote the uptake of newborn care (NBC) practices.

Methods: Baseline data were collected from 90 VHTs on their knowledge, attitudes and practices regarding promotion of newborn care practices. Using these data, we designed a community-based intervention aimed at: a) improving the knowledge of VHTs on NBC practices through training; b) use of trained VHTs to impart knowledge on NBC practices to newly delivered mothers; c) evaluate the effect of the intervention on knowledge, attitudes and practices of newly delivered mothers on NBC practices, after a period of three months.

Results: Of the 90 VHT’s trained, 85 (94%) were assessed. Over 94% (80) were employed and had worked as VHT’s for at least 12 months. Knowledge of newborn care practices was high 90% (77) overall, but specific newborn care practices such as teaching the mother to keep the baby dry (58.8%, 50 of 85), and skin to skin care (57.7, 49 of 85) were average. Knowledge of danger signs such as inability to breast-feed 42.3% (36 of 85), jaundice or yellowness of the baby 38.8% (33 of 85) and rigid infant 18.8% (16 of 85) were the least known NBC practices. A total of 90 VHTs were trained in Maternal Newborn Care package informed using the MOH, WHO and MANEST training manuals. All 90 VHTs promoted newborn care practices in the communities among newborn mothers. Data to assess the effect of the intervention on knowledge, attitudes and practices of mothers with regard to NBC practices have been collected and await analysis. Challenges reported by VHTs while executing their duties were: poor access to households, provision of false information by mothers, and lack of community confidence.

Conclusion: Specific knowledge of NBC practices such as thermal care; inability to breast-feed; and yellowness of baby is low, while limited access to households and lack of confidence among mothers are the most reported challenges faced by VHTs while executing their duties. These are likely to negatively affect the promotion and uptake of NBC practices among mothers. Analysis of data to assess the success of the intervention (fidelity, reach and knowledge and attitude change towards NBC practices among newborn mothers) will be completed by January 2015. This will help in re-designing the PNC strategy.

ABOUT BAYLOR UGANDA

Baylor College of Medicine Children’s Foundation-Uganda (Baylor-Uganda) is an indigenous not for profit child health and development organization affiliated to the Baylor International Paediatric AIDS Initiative (BIPAI). BIPAI is a global partnership established in 1996 at Baylor College of Medicine in Houston, Texas USA working to expand access to paediatric HIV/AIDS services. Baylor-Uganda was established in 2003 at the Paediatric Infectious Diseases Clinic in Ward 15 of the National Referral Hospital Mulago. In 2006, the organization was fully registered as an NGO and currently operates at the Baylor College of Medicine Bristol Myers Squibb Children’s Clinical Centre of Excellence (COE). Further information about Baylor Uganda can be obtained at: http://www.baylor-uganda.org/.
USING EVIDENCE FROM IMPLEMENTATION SCIENCE RESEARCH TO INFORM HIV INTERVENTION SERVICE DELIVERY: EXPERIENCES FROM MILDMAV UGANDA

ABOUT THE FELLOW

Anne Nabukenya is a specialist in Health Services Research. She holds a Master’s degree in Health Services Research from Makerere University School of Public Health and a Bachelor’s degree in Quantitative Economics and Applied Statistics from Makerere University. Anne has 7 years’ experience in managing and analyzing large datasets and 2 years’ experience in implementation of science research projects. Prior to joining the Fellowship, Anne worked as a Data Management Officer with Medical Research Council (MRC)/UVRI Uganda. During the Fellowship Anne was posted at Mildmay Uganda (MUg), a centre of excellence for HIV/AIDS services. While at MUg, she led the implementation of a quality improvement project, an operations research project, and documented and disseminated best practices and lessons learnt at conferences and journal articles. In particular, her research explored the efficacy of the different strategies for improving linkage and retention in HIV care and PMTCT Option B+ services. As a result of the Fellowship training, Anne has enhanced her capacity to develop and conduct implementation science research studies as well as manage and lead programs. Her future plan is to acquire program and research grants to advance implementation science research especially for improving HIV/AIDS service delivery. Anne says, “The fellowship program training is an enriching experience for aspiring transformative leaders. I have enriched my critical and creative thinking as well as managerial, leadership and communication skills.”

Key responsibilities and achievements

Develop and implement an operations research project: I developed and implemented a research project titled “Knowledge of HIV acquisition and its influence on high risk sexual behavior among men after circumcision”. Preliminary findings show that 23% of the 80 men were involved in high risk sexual behavior pre-circumcision. Of these, majority (80%) reportedly continued with such behavior after circumcision. However, of the men who were not involved in risky sexual behavior pre-circumcision, only 8% adopted high risk sexual behavior post-circumcision. Thus, there is need for risk assessment and repackaging of behavior change communication (BCC) messages targeting men seeking circumcision services based on their risky sexual behaviors before circumcision.

Develop and implement a quality improvement project: I developed a protocol for a quality improvement (QI) project titled “Using phone text messages to improve attendance of scheduled HIV care clinic appointment at Mildmay Uganda”. As part of the project, the IT department developed a web portal on the MUg website for sending out phone text messages. However, actual sending out of messages has been delayed due to the fact that MUg’s website is currently under reconstruction.

Document and disseminate best practices and lessons from MUg: I documented two main best practices at MUg. One was presented best practice was also presented at an international conference in London “Opt out model increases coverage of cervical cancer screening at Mildmay clinic”. In this model, we demonstrated that Opt out approach for cervical cancer significantly reduces the proportion of women presenting with advanced cervical lesions and that trained nurses can ably deliver the cancer screening services. We also shared best practices for transitioning older adolescents from pediatric care setting into adult care.

Support the M&E team in implementing a result-based framework: Under the guidance of the M&E Manager, and in collaboration with key staff from all the 18 departments...
at Mug, I led the process of developing key performance indicators and their targets. The indicators and targets are being used for quarterly and annual performance reviews.

By executing various activities and interacting with various people, I improved my leadership skills and gained various competencies. In addition, my communication skills were enhanced through writing and publishing newspaper articles, abstracts for conference and workshop presentations and peer-reviewed articles for publication in international journals.

Other achievements
I was co-opted as an instructor to facilitate sessions on the BSc degree course and several short courses offered by MUg including M&E, proposal writing, research methods and community needs assessment.

Innovations and creativity at the host institution
1. I introduced and pioneered the review of quarterly performance at MUg which is now in practice. This has enabled MUg to streamline and improve departmental performance.

2. I also initiated the idea of using short text messages (SMS) to remind HIV care and treatment clients to attend their scheduled clinic appointments. The IT department at MUg has developed a web portal on the MUg website for text messaging to clients. However, this is still on halt as the host institution website is being upgraded but the process will resume as soon as the website upgrade is completed.

Training and capacity building conducted at the host institution: Besides teaching some designed short courses to participants who at times were MUg staff, I also taught some research methods to staff, supported some to write abstracts for conferences especially offering statistical support and the actual writing. Two staff I supported managed to present their abstracts at a national conference.

Communication, presentations & publications

a) Print media
i. “More effort needed to curb maternal deaths”, published in the Observer Friday 21-23rd July 2013
ii. “To improve health service delivery, address workers poor attitudes toward work”, published in the Monitor 20th May 2013
iii. “Improve health workers attitude”, published in the New Vision online version on 8th May 2013

b) Conference presentations

c) Publications in peer-reviewed journals
i. Nabukenya AM, Matovu JK, Wabwire-Mangen F,

Fellow (in blue top – next to the projector) presenting at a staff performance review meeting
On average, retention rates of mothers and infants at health facilities that implemented peer-mother support and a peer-mother - mobile phone reminders model improved from below 45% to about 70% (p< 0.001). Implementation of retention strategies led to significant improvements in retention rates at all stages of the PMTCT care cascade. For instance, peer-mother support model increased ANC ART refill attendance from 44% to 74% and post-delivery ART refills from 40% to 71%. Similarly, the peer-mother-support -mobile phone reminder model increased ANC ART refills from 40% to 80% while post-delivery refills increased from 44% to 75%. These improvements were significantly higher than the improvements in retention rates observed in health facilities that did not implement any retention strategy. Furthermore, over 85% of the mothers recommended the scale-up of peer-mother support or mobile phone reminders to other health facilities citing its positive influence on psychosocial wellbeing of the mothers.

Conclusion: The peer-mother support model and/or the peer mother - mobile phone call reminder model are effective strategies for retention in PMTCT programs. Lack of spousal support and transport fare as well as non-disclosure of HIV status to family are the key barriers to retention in care.

Policy and public health implications: Scale-up of the peer-mother support model or peer mother support –mobile phone reminders will substantially reduce on missed appointments and increase retention in the Option B+ program cascade. There is need to devise strategies that encourage family or partner participation to enhance support for the mothers.

About Mildmay Uganda

Mildmay Uganda was established in Uganda in 1998 to provide quality HIV/AIDS Care, Treatment, Training and Education. Her vision is “Communities equipped to effectively respond to HIV & other priority health issues” and mission is “Modeling quality and sustainable prevention, care and treatment of HIV and other health priorities, using a family centered approach; together with training, education and research.” Since its establishment, MUg has been an important player in Uganda’s HIV response and is currently implementing the Health system strengthening (HSS) project in 16 districts of central Uganda. Further information about MUg can be obtained at: http://www.mildmay.or.ug/
ABOUT THE FELLOW

Stephen G. Alege holds a Bachelor of Mass Communication and a Master of Arts in Journalism & Communication. He also holds a Post-graduate Diploma in Project Planning & Management. Stephen has over nine years of experience working with non-governmental organizations that has equipped him with cutting edge experience in various disciplines that include strategic health communication management and leadership, implementing high impact Social and Behavior Change Communication (SBCC) strategies, and health product and service social marketing and franchising, among others. Prior to joining the Fellowship, Stephen worked with Program for Accessible Health Communication and Education (PACE) as Communication and Information Management Specialist. During the Fellowship training, he was placed at Uganda Health Marketing Group (UHMG). UHMG is an indigenous organization registered as a not-for-profit business in Uganda. UHMG works towards improving the quality of life of Ugandans through the provision of superior and affordable health care solutions.

During his placement at UHMG, Stephen supported the development, management and evaluation of national and institutional SBCC strategies, and health service and demand promotion strategies in the areas of HIV counseling and testing, family planning, newborn health and elimination of mother to child transmission of HIV (eMTCT). Stephen also engaged in building individual and organizational capacity to effectively execute high impact health communication strategies that resulted in increased behavior and demand for health services and products within a range of 35-45% across various projects and programs. This experience has put him on course to achieving his career development goal of acquiring competencies to develop, execute and monitor cutting-edge life-saving social marketing and health communication campaigns. In his own words, Stephen says, "the fellowship provided me with a once-in-a-lifetime opportunity to share while acquiring skills and expertise in a professional life impacting environment."

Key responsibilities and accomplishments

During the fellowship period the fellow engaged in numerous activities that resulted in significant accomplishments within the agreed upon TORs as indicated below:

Lead in the development of the community mobilization strategy and M&E framework: I took lead in the development of an integrated community mobilization strategy for the USAID/Uganda Integrated HIV Counseling and Testing Project in Kampala. The strategy is currently used to guide community demand creation activities for key populations. In addition, I took lead in the development of quarterly and annual work plans, budgets and reports with support from project team members. I also led the process of facilitating the development of 57 work plans and monthly reporting templates for the Good Life Promoters (GLPs). The detailed work plans includes mobilization activities, expected outputs & timeframe.

Lead the development of a training curriculum and training of GLPs in integrated health services community mobilization: I led the process of developing a training curriculum on integrated health services community mobilization for the GLPs. The process involved development of learning aims, outcomes & lesson plans for the curriculum. I planned and facilitated two 3-day trainings for GLPs that were conducted using the developed training curriculum. Sixty GLPs were equipped with the latest community interpersonal health service seeking behavior change communication skills.

Engage in management-related tasks: I led the planning and facilitation of one of the key populations peer educators.
I spearheaded the development of the peer-to-peer model. This enabled me to acquire various competencies that include strategic thinking, critical analysis, oral and written communication, health communication monitoring and evaluation. These competencies are critical in the conceptualisation, development, execution and monitoring and evaluation of cutting edge health communication and social marketing campaigns.

Develop key result areas and human resource related functions performance indicators for the Community Participation Officer and HCT Coordinator: I spearheaded the development of the Community Participation Officer’s job description and key performance indicators (KPIs) for the Monitoring and Evaluation Manager. The KPIs were derived from the project staffing gaps around community engagement. The developed KPIs guided the Community Participation Officer in the dispensation of her job tasks and were the basis for her annual performance appraisal by the fellow. I was a member of the panel that interviewed the USAID Director for Social Marketing, Behavior Change Communication Officers (4), USAID Communication for Healthy Communities’ Project M&E Manager and reviewed the Global Fund M&E Officer’s job description.

Disseminate final SBCC interventions study findings: Disseminated the findings of the process evaluation study among staff members during two meetings. The final and abridged versions of the report were shared on mail and on the website.

In summary, implementation of the above-mentioned terms of reference enabled me to acquire various competencies that include strategic thinking, critical analysis, oral and written communication, health communication monitoring and evaluation. These competencies are critical in the conceptualisation, development, execution and monitoring and evaluation of cutting edge health communication and social marketing campaigns.

Other achievements

Develop National Newborn Health (NBH) Communication and Advocacy Strategy: I led the development of the National Newborn Health Behavior Change Communication and Advocacy Strategy for Save the Children Fund and Ministry of Health (MoH) on behalf of UHMG. The strategy development process was informed by a national assessment of NBH communication messaging conducted in fourteen districts. The draft strategy was shared with Save the Children Fund and MoH and revised based on comments received. A final strategy was eventually produced and approved by MoH.

Write grants proposals: I was engaged in the development of funding proposals across various health areas. During this process, I took part in the writing of six proposals, three of which were submitted to USAID and the rest to other funders. One of these proposals was funded to the tune of $40,000. Other proposals are still under review. During the writing process, I was able to improve his research, analytical, writing communication, negotiation, proposal writing and activity costing skills.

Assess national health communication materials: I led a team that assessed health communication materials for Communication for Health Communities on behalf of UHMG. The findings of the assessment formed the basis for the development of new health communication materials. This process equipped me with health communication assessment, review and evaluation skills.

Supervise communications and marketing team: While at UHMG, I acted as the Head of Communications and Marketing for the Integrated HIV Counseling and Testing Project. In this capacity, I supervised the BCC Manager, the Brands Officer and the Community Engagement Officer.

Improve partner clinic/client data management: I led the organization and management of the partner clinic client data using the 5S approach. Specifically, the data were sorted by clinic and date, entered into an electronic database, and the hard copies were filed in box files and transferred to a secure organized storage facility. This process tremendously improved efficiency by eliminating waste, improved client flow and reduced process inefficiencies. The experience enhanced my skills in quality improvement.

Develop a peer-to-peer conceptual service delivery model: During the project strategy change process, I participated in the development of the conceptual peer-to-peer model. This enabled me to acquire conceptual skills.

Develop the Good Life Clinic (GLC) Manual: I contributed to the development of the UHMG GLC Manual by writing a section of the Manual. This strengthened my writing skills. I also led the process of developing the UHMG’s Operational Research Guidelines. The draft was shared with project team members and is currently undergoing review. This equipped me with strategic, critical analysis and writing communication skills.

Build partnerships and capacity of key population partners: I spearheaded the development of partnerships equipping Women Organizations Network for Human Rights Advocacy (WÔNETHA), Youth on the Rock and 66 peers with new mobilization, motivational, referral, community mapping, peer follow up and periodic reporting knowledge and skills. In so doing, I enhanced my oral, written communication and analytical skills.

Innovations and creativity at the host institution
During the fellowship, I introduced the tracking of Good Life Promoter (GLPs) referrals as a basis for payment. As
a result, there was an increase in completed referrals and a reduction in the amount of money spent on payment of GLPs. Non-performers were dropped and new GLPs recruited.

Communication, presentations & publications

a) Print media
I wrote and published two articles which were published in the online newspaper version and the other in the printed version respectively, as shown below:

- “Revising restrictive abortion laws will save our mothers’ lives” (New vision online, September 15, 2013)
- “Behaviour relapse fuelling new HIV infections” (New Vision, July 12, 2013)
- “Delayed breastfeeding killing our new-borns” (New Vision, April 4th, 2013)
- “Increasing HIV infection among housemaids and house wives a big concern” (New Vision online (November 29th, 2013)

b) Conference presentations
I wrote and presented four abstracts to local and international conferences as follows:

- Alege GS, Ngabirano T, Ochieng D, Watulo J, Ahairwe D, Ssendija M, Tweteise A, Matovu JK, Nabiwemba E. Working with private health clinics to link key populations to HIV Care services in Kampala, Uganda. Oral presentation at the 9th International Conference on HIV treatment and Prevention Adherence, Florida, USA: 8th-10th June, 2014.
- Alege GS, Matovu JK, Ssensalire S, Nabiwemba E. Knowledge, Sources and Use of Family Planning Methods among Women of Reproductive Age in Uganda. Oral presentation at the 10th Joint Annual Scientific Conference of Makerere University College of Health Sciences, Kampala, Uganda: 29th-30th May, 2014
- Alege GS, Ngabirano T, Ochieng D, Watulo J, Ahairwe D, Ssendija M, Tweteise A, Matovu JK, Nabiwemba E. Working with private health clinics to link key populations to HIV Care services in Kampala, Uganda. Oral presentation at the 9th International Conference on HIV treatment and Prevention Adherence, Florida, USA: 8th-10th June, 2014.

b) Manuscript submitted to a peer-reviewed journal

d) Manuscripts in preparation
- Experiences of Providing HIV Counseling and Testing (HCT) Services to Blue Collar Populations in Kampala, Uganda, using the Mobile Van approach
- Social Marketing Campaign to Improve uptake of HIV Counseling and Testing Services in Kampala, Uganda

Programmatic Activity Summary

Process evaluation of the social marketing campaign to improve uptake of HIV counseling and testing services in Kampala, Uganda

Introduction: HIV counseling and testing is a key entry point into HIV care and treatment. In Kampala, about 96% of the adult population knows where to get an HIV test but only 44% have actually tested for HIV. It is therefore important that many people get to know their HIV status through taking an HIV test. We implemented a social marketing campaign (dubbed: ‘Put Your Love to the Test’) to improve uptake of HIV counselling and testing services in Kampala, Uganda. We conducted a process evaluation of the campaign to evaluate the implementation modalities and early results of the above-mentioned campaign.

Methods: The process evaluation was conducted among men and women (18-49 years) living in two divisions of Nakawa and Kawempe divisions since July, 2013. Data were collected on socio-demographic and behavioral characteristics, exposure to the campaign, channels-mix, effect of the different channels in reaching the intended audiences, proportion of the exposed audience that accessed HCT, and among those not accessing HCT, reasons for not doing so. Data were entered into Epi info 7 and analyzed using SPSS and STATA.

Results: Overall, 858 respondents were interviewed. Of these 816 (95.1%) were exposed to the campaign. Those exposed to the campaign were generally young, 36.2% were aged <25 years, 43.6% were married or cohabiting, 62.8% had attained primary or higher education, while 54% earned < 100,000 shillings. Of the 816 exposed to the campaign, 40% (326) took an HIV test while 4% reported that they discussed HIV testing with their sexual partner. Of the 490 (60%) who did not test for HIV, 45.8% cited low HIV risk perception, 18.9% cited fear of stigma & discrimination and 17% cited faithfulness to a partner the main reasons for not seeking HCT services. Majority of the respondents exposed to the campaign (816) were reached by mass media (41.5%), interpersonal communication (21.1%), and billboards (20.5%). The ‘Put Your Love to the Test’ Campaign was implemented for the first one and a half years however, after six months of implementation; most of the social marketing channels were stopped.

Conclusion: Majority of adults in Kampala have been exposed to the ‘Put Your Love to the Test’ campaign. The campaign largely reached young people and low income earners. Over half of those reached by the campaign undertook a positive HIV prevention action such as using condoms, abstained from sex, became faithful or told other people about the importance of HCT. Those that did not take any action were hindered by a low perception of HIV contraction risk among others.

Policy and public health implications
- Future campaigns targeting generic populations should continue to use mass media channels to influence behavior choices through well-crafted and appealing health communication messages to the audience of interest.
- Future studies should look at the effectiveness of community health workers in reaching urban based populations with health behavioral messages.
- HIV communication projects and future social behavioral change communication campaigns should target the key barriers to the adoption of HCT behavior among the Kampala adult population that has been established in this study such as limited individual perception of HIV infection risk.

About Uganda Health Marketing Group
Uganda Health Marketing Group (UHMG) is an indigenous, not for profit organization founded by reputable public health and social marketing Ugandan professionals in 2006. UHMG strives to deliver the Good Life to all Ugandans through high quality strategic health communication and accelerating health market growth. UHMG works in four key health areas (HIV/AIDS, malaria, family planning, maternal and child health), UHMG envisages a Uganda where families and communities are empowered to protect and improve their health; where markets for health products are vibrant and expanding. UHMG develops evidence-based campaigns designed to spark Ugandans to make life-saving health decisions. Through innovative marketing and social communication platforms, we create demand for health services and products at national and community levels. Further information about UHMG can be obtained at: http://www.uhmg.org.
MATTHEW LUKWIYA AWARD

Background to the Award

The Matthew Lukwiya Award is given in recognition of the outstanding commitment and dedication exhibited by Dr Matthew Lukwiya during the treatment of Ebola-infected patients. He died in the process. Dr Matthew Lukwiya was a physician who obtained his Masters of Public Health at Makerere University School of Public Health. He was working at Lacor Hospital at the time of the Ebola epidemic in 2000. Dr Lukwiya not only showed remarkable outbreak investigation skills by recognizing the clinical manifestations of Ebola infection and having specimens tested to confirm the infection, but also outstanding leadership by running the Lacor clinical team Dr Lukwiya understood the risks that he and his colleagues were taking while caring for patients during the epidemic. At the funeral of an Italian nun on 7 November 2000, he attempted to rally the morale of his workers: "It is our vocation to save life. It involves risk, but when we serve with love, that is when the risk does not matter so much. When we believe our mission is to save lives, we have got to do our work." However, despite instituting risk minimization procedures, including wearing of robes, multiple gloves, surgical masks and goggles, hospital workers continued to fall ill. But he was dedicated to his patients and to public health and he commented before he died that he would "continue fighting Ebola alone if necessary until the virus is beaten or until I am dead". Tragically, his willingness to continue caring for patients and leading his health care team also led to his death by Ebola acquired while caring for a patient with the illness. 

MakSPH instituted an award to honor Dr Matthew Lukwiya, to be given out to any long-term Fellow who has demonstrated personal sacrifice, devotion, and leadership in carrying out professional responsibilities during his/her apprenticeship at a host institution. Dr Matthew Lukwiya exhibited the following qualities which are considered in selecting the Matthew Lukwiya Award winners: Leadership potential, dedication to career, commitment to program goals, professionalism, innovativeness, productivity and selflessness.

Matthew Lukwiya Award recipients

Nine Fellows – one per intake – have received the Matthew Lukwiya Award since the Fellowship Program was initiated. The table below shows the different Matthew Lukwiya Award recipients since 2002.

<table>
<thead>
<tr>
<th>Name of Fellow</th>
<th>Intake</th>
<th>Date Award Given</th>
<th>Awarded by</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Ms Gloria Katusiime</td>
<td>October 2002-2004</td>
<td>December 18th, 2003</td>
<td>Mr Sam Ngobi, Academic Registrar, Makerere University</td>
</tr>
<tr>
<td>3. Dr George Didi Bhoka</td>
<td>October 2003-2005</td>
<td>December 2nd, 2005</td>
<td>Prof Livingstone Luboobi, Vice Chancellor, Makerere University</td>
</tr>
<tr>
<td>4. Dr Stella Alamo</td>
<td>October 2004-2006</td>
<td>January 19th, 2007</td>
<td>Dr Emmanuel Otaala, Hon. Minister of State for Primary Health Care</td>
</tr>
<tr>
<td>6. Dr Alfred Geoffrey Okiria</td>
<td>April 2008 – 2010</td>
<td>March 26th, 2010</td>
<td>Prof Venansius Baryamureeba, Vice Chancellor, Makerere University</td>
</tr>
<tr>
<td>7. Mr Jotham Mubangizi</td>
<td>May 2009 - 2011</td>
<td>May 10th, 2011</td>
<td>Dr Tadesse Wuhib, Director, CDC Uganda</td>
</tr>
<tr>
<td>8. Mr Ediau Michael</td>
<td>April 2010 – 2012</td>
<td>May 4th, 2012</td>
<td>Dr Tadesse Wuhib, Director, CDC Uganda</td>
</tr>
</tbody>
</table>
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