Welcome to yet another issue of MESAU News, a publication of the national consortium of medical institutions in Uganda which remain focused on their vision — Medical Education for Equitable Services for All Ugandans (MESAU). There is an ever increasing demand and determination across all sectors of our society, both public and private, to bring about change in the quality and access to health service delivery throughout the country. Last week, July 25 and July 26, 2012, the Makerere University College of Health Sciences lost two promising medical students ... one in second year medicine (Allan Mulalira) and the other in third year nursing (Alice Nabukeera). Alice died from a road traffic accident involving a motor cycle (Boda Boda) and Allan died of leukemia. These deaths are a stark reminder of the increasing burden of illness morbidity and mortality) from non-communicable diseases. As we mourn their deaths we agonize with the question of how could these premature deaths (21 and 22 years old respectively) have been avoided?

Ugandans have been long concerned about the extremely unacceptable situation of health workforce in Uganda and now look to MESAU as one of the national efforts to bring about change.

Students can and should drive change in our institutions. They have taken up this challenge. This is reflected in the several articles they have contributed to this issue of MESAU News.

On behalf of the Ugandan people I wish to thank our supporters and most especially the American taxpayers for the generous contributions towards our struggle to work towards significant improvements in medical education for better health service delivery and with an equity perspective. All this is made even more meaningful because of Uganda government readiness to play its role.

Prof. Nelson K. Sewankambo

Addressing the challenges of the Health workforce:
Innovations for attraction and retention in Uganda
By Charles Isabirye Principal Health Officer (MOH) & Lukia Nakamate Communication Specialist, MOH Uganda

Health workers are the most important component of any Health System: they design it, manage it, and deliver preventive and curative services. They are also the largest component covering 60% or more of the total health budget of the health care system. In Uganda, human resources take approximately 45% of the budget in form of salaries, wages and allowances. When the health workforce falls critically short, as is the case today, disease will spread rapidly, and in the absence of cure and care, a large disease burden, a high mortality rate, and a low life expectancy result.

According to the WHO countries with, on average, less than one doctor, nurse or midwife per 439 inhabitants suffer from a critical shortage of health workers. In our case, that ratio is 1 per 1,236 inhabitants. Of this limited workforce, 70% of the doctors and 40% of the nurses and midwives serve no more than 12% of the population. Productivity of the health workforce is low. Life expectancy of a newly born Ugandan is around 50 years of age; the people and the Ugandan labor force are hit hard by disease and death.

Reports and ongoing fact finding efforts about the prevailing health workforce problems and challenges have revealed many factors underlying the present limitations of the Health Workforce. Ineffective leadership and management are addressed. The population would also benefit substantially if the recruitment and equitable distribution of workers follows the population distribution as opposed to the current urban polarization that leaves the rural population to the mercy of charlatans.

Gulu University Medical Students Promote MEPI-MESAU Goals
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Addressing the challenges of the Health workforce: Innovations for attraction and retention in Uganda

Management of the health workforce as well as the actual management at all levels need revisiting and simplifying. At the highest level, five ministries namely Health, Education and Sports, Local Government, Public Service, Finance and Economic Development; and two political levels i.e the Central level, and Decentralized level, are responsible for the health workforce development and maintenance.

To address these numerous challenges with attraction and retention of the health workforce in the country, government is undertaking a number of innovations and they include:

1. Increasing access to health workers in remote and rural areas through improved retention to ensure adequate workforce for effective delivery of the UNMHP. In the financial year 2011/12, the Ministry of Health as an interim measure mobilized Ug Shs. 5.4B from its own annual budget to assist the districts to improve their staffing levels in rural areas through deployment of 490 doctors, pharmacists and graduate nurses who completed internship training in August 2011. This is a temporary measure as the Ministry continues to engage the central government to increase the resource envelop for the sector.

The officers will also, on bonding arrangements, automatically get scholarships for their further training in Uganda. The Ministry of Health is also negotiating with the central government to secure a loan of not less than shs8m for each one of them payable within two years of working. The initiative is expected to continue till government provides funds for recruitment of health workers.

The Ministry of Health also secured funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria, to recruit 600 health workers targeting improvement of staffing levels in the hard-to-reach areas and will continue interfacing with the various partners in health development to support addressing issues and challenges affecting the health workforce in the country. It is envisaged that these initiatives will improve staffing levels in the district from the current 42% of the skilled health workforce to 65%.

2. Improving the working conditions through construction of staff houses; improved availability of medicines and other health supplies due to the introduction of the ‘PUSH’ System. Government has also provided equipment to health facilities and has fully functionalized the level four Health centers (HCIVs). This has been beefed up with enforcement and compliance of the Work Safety Policy and Guidelines. Government has in addition provided bursary/scholarship schemes for the health workers, introduced various capacity development programmes on leadership, governance and management of health facilities to empower them with managerial and leadership skills. The managers at various levels are undergoing fully sponsored training in short and long courses at various institutions in view of building capacities for management, leadership and stewardship for HRH at all Levels. Supportive supervision is also being provided through mentoring and coaching to ensure regular supervision of staff at all levels. Furthermore, the Ministry of Health is institutionalizing and enforcing the performance management practices such as introduction of performance contracts as a means of improving productivity of the workforce.

Government has on an annual basis been increasing salaries of health workers though not yet commensurate with the workload and current cost of living in the country.

3. In line with “The Global Code of Practice” government is drafting mechanisms to address the issues of staff migration in Uganda, especially the high-skilled health cadres.

4. Due to the country’s liberalisation policy for investment, investment in both service delivery and health training is vibrant. Currently, there is a network of eighty-nine (89) public and private recognized health training institution in the country and these include; five (5) Universities training doctors, nurses and other professionals at degree level, forty-seven (47) schools training nurses and midwives at certificate and diploma level and thirty-seven schools training paramedicals in various courses also at different levels. The country’s average annual skilled health workforce production has tremendously increased with 300 medical doctors; 100 pharmacists; 7,500 various categories of nurses/
Addressing the challenges of the Health workforce: Innovations for attraction and retention in Uganda

midwives, and over 300 Clinical officers.

As much as the country is trying its best to address the Human Resources for Health (HRH) issues as indicated by what is being done above, there are still enormous challenges ahead some of which are outlined here below;

a. Inadequate wage bill to recruit and meet the planned targets

b. Change of Policy in management of the health workforce as a result of the Local Government Act, 1995 that decentralized government services including those of the health sector.

c. Districts are not eager to allow their doctors to proceed for further training because they get a wage bill burden of those officers who proceed for further training especially at specialist level. It is stipulated in the Public Service Standing Orders that an officer on study leave continues to receive salary until he/she completes training and is redeployed.

d. Planning for the health workforce and the entire health sector is constrained by the constrictive resource envelope. The country’s meager budgetary allocations to the sector resource envelope affect allocations for training of various categories of health professionals.

e. Other factors among which is the poor working environment; increased workload due to expanding health services and stringent staffing structures, and low salaries versus the increasing cost of living/numerous taxes put on salary pay.

f. Increasing Health workforce migration is continuously threatening the health sector. In some cases health workers move from the public sector to private; leaving rural areas for urban environments to earn extra income, look for better social amenities, or/and nongovernmental organizations/agencies/multilateral organization. Some times they leave their home country looking for better working conditions and career opportunities elsewhere. The result is increasingly inequitable access to health care, within and between countries.

Much as the situation may appear pathetic as far as addressing health workforce crisis in Uganda is concerned, the country is committed, trying its level best and is focused on mitigating the HRH issues with the available resources, so as to avail people in Uganda equal access to quality essential health services in line with the development goals of the country. The efforts MESAU partners and all other training institutions are highly appreciated as essential partners of the Ministry of Health.

TURNING THE TIDE TOGETHER

Last week the XIX International AIDS conference (AIDS 2012) was held in Washington DC, USA with the theme – Turning the Tide Together. This theme also fits very well with MESAU’s approach to addressing the inadequacies of the Uganda’s health workforce. MESAU upholds the principle of togetherness and partnership with all stakeholders. That is why the medical education institutions are working together as a consortium to turn the tide of inadequate health workforce. However, education institutions need the support and collaboration with various government departments for example ministries of Education, Health, Finance and Local Governments; the private –for-profit and non-profit sectors, society or communities at large, non-governmental organizations, and funders (Bilateral and Multilateral agencies, Foundations). If we remain steadfast with our vision MESAU will be counted in history as the cornerstone in causing a social movement that is likely to sweep across the country in reforming medical education to ensure equitable services to all Ugandans. Those that say it can’t be done should get out of the way of those doing it’…a Chinese proverb.

Though early in our existence as a partnership, we are at defining moment and are well advised to remember the statement by Robert L. Stevenson “Don’t judge each day by the harvest you reap but by the seeds you plant”. We know where we are headed but we also know that for seeds to grow and yield bumper harvests that we are eagerly looking for; that are repeated year after year or season after season, sustainability of effort is critical. Now is the time as we plant the right seeds to be strategic and examine carefully, develop, and implement concrete plans for sustainability of MESAU efforts above and beyond the current MEPI funding. It is an inescapable fact that each of us and collectively will be judged by history as to how we performed in caring not only for the present generation but also for our children and our children’s children and generations to come. Country ownership and investments in these efforts are vital and should be measurable along with the impacts accruing from the investments and MESAU activities.
MESAU’S Monitoring and Evaluation System: One Year Later

By MESAU M & E Team

In the first project year MESAU dedicated considerable time and effort to developing an M&E system which consists of the logic model, the performance monitoring plan and the work plan. The motivation for this and the process we went through were detailed in MESAU’s maiden newsletter using Moses and the Exodus story to illustrate the importance of M&E. A year after completing the development of our M&E system we ask ourselves whether it has served its purpose or whether we are wandering, directionless and lost in the desert like the Israelites.

What we are doing well
MESAU PI Professor Sewankambo is pleased that MESAU invested in developing a comprehensive and implementable M&E plan with clear indicators and outputs. Moreover, the M&E plan was not just shelved but is actually being implemented and referred to on an annual basis to shape the next year’s work plan for MESAU. As such, the M&E Plan enhances accountability within MESAU and to the funders. He adds that by using the M&E plan, MESAU has been able to identify weaknesses and gaps in project implementation and take corrective measures. Importantly, using a common M&E plan has contributed to enhancing cohesion and partnership by placing similar demands on all institutions for cross cutting activities.

Ms. Ruth Nabaggala, the M&E Officer who was recruited soon after the development of the M&E Plan observes that it has contributed a great deal in directing the implementation of project activities. The way the M&E plan was designed helped her to understand the project (which she joined one year into implementation), to track MESAU performance at operational and strategic levels and to compare performance between institutions and assess if planned targets have been achieved. She adds that the implementing committee at each MESAU partner institution has played a critical role in implementing the M&E Plan.

Each institution has an M&E focal person who oversees M&E activities with technical support from the M&E Officer. The M&E focal persons say that the M&E plan is a yardstick for measuring progress. Being universal to all MESAU institutions, the M&E plan has enabled the institutions to have the same reflections with the result that they can easily learn from each other. This enhances collaboration and strengthens the partnership between MESAU institutions. At KIU, the M&E plan has specifically been very instrumental in priority-setting for implementation of activities, while at Gulu University part of each monthly implementation committee meeting is allotted to M&E, thus making collection of data by the focal person easy. Similarly, MakCHS has monthly implementation committee meetings during which activities and achievements of the previous month are reviewed, and targets set for the next month. Furthermore, the institutions have benefitted from having a MESAU M&E Officer who gives support through meetings, e-mails and physical visits. Best practices from one institution are then shared by all for the benefit of everybody else.

What we are doing not so well
While the M&E plan is comprehensive and has served its purpose to a great extent, the implementation is not without some challenges. Some activities are not fully implemented as per the scheduled timeframe due to institutional limitations, the most important one being human resource and the challenge of balancing academic, administrative and clinical work. Reporting has been less than optimal both in terms of timing and content, thus leading to incomplete data capture which gives an incomplete picture and description of achievements and challenges. This particularly applies to targets achieved earlier than planned, and to unexpected positive outputs. Another challenge has been inadequate utilisation of the performance monitoring plan which was developed alongside the M&E plan. There are also some fundamental organisational/institutional challenges such as the incomplete shift to digitised data, which is aggravated by incompleteness of data even in the paper form. This greatly hindered the determination of baseline data. Although there has been some reflection and mutual learning during joint MESAU meetings, the M&E focal persons have not had as much close interaction as would have been desired to share their successes and challenges and to stimulate deeper thinking and transmission of innovations across the consortium. Another cause for concern is that the M&E data and experiences particularly of the second year have not been transformed into manuscripts for publication. Lastly, not all faculty, let alone members of the institutional implementation committees understand M&E and its functionalities. Thus, M&E is sometimes interpreted as “policing” and this hinders its effectiveness.

What we intend to do better
Collecting and documenting quarterly achievements and challenges will be improved by customising the work plan to teams/committees as specified in the performance monitoring plan, so as to ensure completeness in capture of both qualitative and quantitative data. This is in contrast to the current practice of providing the whole work plan and expecting individual teams/committees to fill in their respective small pieces. In order to further support effective reporting, we propose that members of faculty and administration who have reporting responsibilities are oriented in the principles of M&E so that they gain a better appreciation of the function and value of M&E. Communication and interaction within the M&E team will be strengthened through the use of regular electronic meetings.

We borrow from the concluding paragraph of the article on M&E in the maiden edition of MESAU News to summarise what our M&E plan has meant to MESAU over the last year: We have determined baselines as far as we possibly can and we therefore have a good picture of where we have come from. We have had several opportunities to appreciate how far we have come: during our joint annual meeting in October 2011; during the site visit in April 2012 and while preparing the annual progress reports. We only need to pop the champagne!! Because we have clear goals and objectives, we recognise there is still a lot ahead of us and that we still have a lot to go through, whilst remaining focused on where we are going and why. At about this time last year the idea of evaluating the impact of community-based education, research and service had just been introduced into the M&E plan, and it appeared like an ambitious and daunting task. A year later, we have completed most of the baseline data collection and are looking forward to sharing our findings. Shared learning remains at the heart of MESAU M&E as we move closer to outcomes and impact.
"The smallest Action is better than the greatest intention."
~ John Burrough.

The emergence of the Technical Working Groups (TWGs) concept in MEPI programs implementation was a well thought out strategy and manifestation of a maturing program; thanks to the innovators. Any maturing program will always attract secondary and tertiary levels of thinking which delivers new specialities that attract new brains and players to strengthen a more focused action in attaining the primary goal. In the same context the introduction of TWGs has attracted a new form of thinking and thus new players who currently appreciate MEPI and its projects better than before.

Responding to discussions and calls from different MEPI/MESAU meetings and communication Kampala International University (KIU) has attracted faculty and students into serious engagement towards TWG formation. The latter has been enforced by active mobilization and sensitization of the M&E team. Clear in focus is the progress so far made by the Graduate tracking TWG.

In this issue we share the progress and achievements made so far:

- A team has been formed including, Dr. Kintu Mugagga (team leader and Head of M&E), Dr. Surat Akib (Ass. Dean, Faculty of Clinical Medicine), Mr. Ephraim Kisangala [4th Year student –MBChB], Dr. Adedeji Ahmed (Asst. DVC KIU-WC). The group has registered its interest with MEPI- Coordinating Centre and has been invited to participate in discussion during the MEPI Annual Symposium to further the concern about graduate tracking.

- Guided by Action Plans in TWG implementation [from MEPI Medical Education Workshop: Linking Medical Education And Health System Strengthening at Stellenbosch University, Cape town, June 6th to 8th, 2012], our graduate tracking TWG is engaged in research and discussions focused on generation of baseline information upon which a Standard Graduate Tracking Framework is to be established for all MEPI institutions.

- A study questionnaire seeking opinions about knowledge and experiences in graduate tracking (from Pre-admission to Medical school up to deployment as Medical officer) and the effects of brain drain on MEPI institutions, is ready for pre-testing and subsequent application.

- As KIU our action is focused on making a contribution to the development of a Frame Work for Physician Tracking which shall include both a minimum standard for counting and locating physicians and a menu of system factors required for tracking systems.

Our ultimate goal is provision of a lasting /sustainable solution in building capacity and retention of health workers in remote / underserved areas.

We wish to appeal to our sister MEPI institutions and most especially the MESAU consortium to closely network in establishment of an effective Graduate tracking system which shall identify the root-cause problems for poor retention of graduates in remote areas and at the same time generate viable and sustainable solutions.
Family Medicine Interest Clubs: Students Actively Promote Family Medicine at Three Ugandan Universities.

Dr. Besigye Kabahena Innocent (MakCHS) Assistant Lecturer, Dept. of Family Medicine
Dr. Namatovu Jane (MakCHS) Lecturer and Chair, Dept. of Family Medicine

Family medicine was a concept mainly developed in western countries, starting with postgraduate training in the 1960s. It is not a well understood specialty in most parts of the world and more so in Sub Saharan Africa. As a result, efforts to scale up training and practice of family medicine have not achieved much success. Even in developed countries where family medicine has been practiced for many years, there has been a noted decline in the number of students joining family medicine training. It’s as recent as 1963 when the first professor of family medicine in the world was appointed.

There is an urgent need to train large numbers of Family Physicians to provide a constant and trusted entry point into the health care delivery system in order to streamline and improve the health systems in the different countries of the world. At the 62nd World Health Assembly, it was unanimously agreed that primary care and family medicine should be the basis of health systems and that countries should be urged to train enough primary care workers including family physicians with appropriate skills mix to respond effectively to peoples’ health needs.

Family Medicine training programs and the association of Family Physicians of Uganda are seeking creative ways to cultivate students’ interest in Family Medicine. In Canada, Family Medicine interest clubs have done better in informing students about the range of opportunities and rewards offered by careers in family medicine.

In Uganda, the training of Family Medicine was started in 1989 as Community Practice by Prof. John Ross a Canadian Family Physician. The same training was started at Mbarara University of Science and Technology in the early 1990s as integrative medicine and the nomenclature was later harmonized at both universities to Family Medicine to match international nomenclature. For over 20 years, a total of less than 50 Family Physicians have been trained. Due to the low numbers of Family Physicians, the practice of Family Medicine in Uganda is not visible and therefore, medical students are not readily exposed to Family Physicians to act as role models and/or mentors. This has resulted into few medical students later enrolling for family medicine training at postgraduate level despite the glaring need for family physician in Uganda.

At the second Annual National Family Medicine Conference in Uganda, an idea of initiating Family Medicine Interest clubs was conceived by the undergraduate medical students who represented their respective Universities. So far, Family Medicine interest clubs have been started at Makerere University, Mbarara University of Science and Technology and Gulu University. Gulu University does not have a department of Family Medicine, Mbarara University of Science and Technology has a department of Family Medicine but with no active Family Medicine training currently. Therefore, these Family Medicine interest clubs are under the stewardship of the department of Family Medicine at Makerere University where active Family Medicine training is taking place.

Staff from the Department of Family Medicine have visited these interest clubs at both Gulu and Mbarara University of Science and Technology and there is constant communication online between these clubs and the department of family Medicine at Makerere University. At the recently concluded Federation of African Medical Students’ Association (FAMSA) International scientific conference held at Acholi Inn Gulu, Dr. Jane Namatovu and Dr. Besigye Innocent conducted a 2-hour Family Medicine sensitization workshop on invitation through the Family Medicine interest club at Gulu University. Many participants attended the workshop and very good responses were received. Many questions concerning family medicine discipline were asked and answered and we have so far received some applications from Gulu University medical students requesting to do their elective placements in the department of Family Medicine at Makerere University to learn more about the discipline of Family Medicine.

We are in discussions to start Family Medicine Interest Club Consortium (FMICC) between Makerere University, Mbarara University of Science and Technology, Gulu University and Kampala International University to promote and advocate for Family Medicine in Uganda, East Africa and Africa as a whole. The biggest challenge facing these family medicine interest clubs is lack of funding as they are not catered for in the budget of the University. The activities of these interest clubs are purely funded by students themselves through small contributions to buy stationery and other requirements. Financial support either from Universities or other funding agents needs to be solicited for these interest clubs to achieve their objectives. The departments of Family Medicine at the respective universities need to actively support and guide these clubs. There is also need to establish departments of family medicine in universities where they do not exist so that these clubs do not exist in a vacuum.
Challenges of Staff Retention in African Universities: What is the Solution?

By Roy Mubuuke Gonzaga, Makerere University

The African continent in general and Uganda in particular face a huge challenge in terms of skilled health human resource capacity, which has a negative effect on its ability to make strides in the areas of socio-economic and political development. While various efforts have been put in to address the problem, there seems to be little progress, due to a variety of reasons, particularly, the inadequate investment in education and other training programs. Thus, while the World Bank, for example, made significant investments in capacity building initiatives in several countries during the 1990s, these initiatives have not generated sustained human capital benefits for the countries. In Uganda, even the narrow base of skilled university staff is being eroded at a very fast rate by the outflow of professionals to more developed countries of the world. An evaluation of higher education in Africa, Uganda inclusive, over the last two decades, suggests that institutions are surrounded by a multitude of challenges which affect their ability to function as the centers of intellectual excellence that they are supposed to be. Uganda is losing, in significant numbers, a fundamental factor in her socio-economic and political development – i.e., her intellectual capital.

The problem even becomes bigger for health professionals in Ugandan universities who are abandoning these institutions and finding fulfilling employment and satisfaction elsewhere. Academic staff retention is a global challenge which affects both developing and industrialized countries. Health Professions education has been particularly hard hit. The situation has degenerated to the point where there is the possibility of the “inability of some programs to comply with the faculty requirements for accreditation and the risk of students being inadequately trained due to critical shortage of quality academics, as observed by Daniel Laskin in ‘Facing the Problem of Faculty Recruitment and Retention’. The issue of academic staff attrition and retention in developing countries has been less well documented in the literature and the need to investigate the extent of this challenge is thus urgent. As globalization takes shape, it is becoming abundantly clear that full, effective, and beneficial participation in the world that is emerging, will depend, significantly, on the ability of countries to build and take advantage of their human resource capabilities. In the absence of such capabilities, Uganda cannot expect to compete at an appreciable level with her counterparts, not only in the industrialized world, but also from other developing areas which have made the investment and developed the relevant structures and mechanisms to train and retain staff in academic institutions.

A well-developed human capacity base is not only an asset that enables countries to promote forward-looking ideas, initiate and guide action, and build on successes; it also makes those countries attractive destinations for investment and intellectual collaboration, both of which, if managed appropriately, will lead to positive transformation of the community. A solid higher education base, health sciences particularly, is crucial for such transformation to take place. Unfortunately, much of the expertise base of African universities has been eroded to the extent that there is not enough capacity to provide quality training for new generations of citizens. This is due to a variety of factors that include: inadequate and non-competitive salaries vis-à-vis local and international organizations, and lack of job satisfaction due to non-monetary reasons. However, all is not lost. The following suggestions for remedial action, based on good practices from around the world, in general, and Africa, in particular could be a starting point if we are to retain quality academics:

Appointment and Promotions: We should avoid the frustration and bureaucracy of appointment and promotion processes and foster transparency, by ensuring that they are devolved to faculties, and anchored in a representative committee system at every level. There should be a balance to the weighting of teaching, vis-à-vis research, in promotion, merit increment, and tenure decisions.

Institutional Governance and Workplace Climate: Concerns should be addressed around governance, at units and institution-wide levels, through the establishment of representative committee structures, transparency in decision making, genuine consultative processes, and open channels of multi-directional communication between staff members and central administration. Staff members should also be willing to participate in these structures and processes, and have a responsibility to keep them informed about various guidelines, regulations, and procedures.

Teaching, Research and Professional Development: Universities should insist on an optimum level of student intake, under current circumstances, to address workload problems; Provision of institutional support for mentoring programs is paramount; institute starter grants and ‘Innovation Grants for Junior Academics’; increase research and conference grants; forge research linkages with other institutions in Africa and abroad, as well as with governments and the private sector. Here at Makerere University and other partner universities, research funds from MESAU to both faculty and students, is a positive move to addressing this challenge.

Makerere University staff at one of the graduation ceremonies. The University has been faced with challenges of staff retention due to a number of reasons

Salaries and Benefits: There should be a system of differential rewards. This is inevitable, if certain academic fields are to attract and retain quality staff. Governments need to substantially remunurate University staff, but also, institutions need to actively engage and mentor staff into skills of attracting grants through projects which can sustain them as well. Senior staff can mentor junior staff in skills of writing competitive winning projects. However, academics are not only motivated by money and Universities should maintain, or institute, non-salary benefits such as tuition waivers/ remissions, research fee waivers, preferential admission for staff and their families, and access to childcare and primary school facilities provided by their institutions.
Role of Governments, the Private Sector, and International Partners: Governments should increase financial support to universities, but also University administration should spear head partnerships with International and private sector bodies not only to strengthening the quality of teaching and research, but also to motivate academic staff to stay at those institutions. African universities should also continue to cooperate among themselves in ways which give them the ability to share resources and draw from the synergies that collaboration among scholars brings. The MESAU consortium is yet a shining example of such useful collaborations. The large number of graduates, from African universities, living abroad should be mobilized, through alumni and other networks, to support library acquisitions and generation of funds for their home institutions to enable them attract and retain the best staff.

Sustainability and Legacy: Mapping the Genesis of an Evolution in Medical Education in Uganda

David Kaawa-Mafigiri, PhD, MPH, School of Social Sciences Makerere University

The 2012 London Olympics provides an up-to-the-minute and apt starting point for reflection. The successful delivery of such a grand show will depend on collaboration and partnership between various stakeholders including public and commercial funders as well as two key organizations - the London 2012 Organizing Committee (LOCOG) and the Olympic Delivery Authority (ODA). LOCOG and ODA demonstrate that hosting the games, overcoming challenges and ensuring a lasting legacy requires a team effort. A similar team effort is needed to address the challenges Uganda is facing regarding human resources for health.

Although collaborations and partnerships between the institutions that comprise MESAU existed before MESAU (e.g. MJAP in which MakCHS and MUST are partners and THRIVE, a consortium in which MakCHS and GU are members), MESAU represents the first time all medical-training institutions in Uganda have formally partnered to address the challenges of medical education in the country. MESAU’s goal is “to establish its constituent institutions as centres of excellence for medical education, research and services that address local and national needs to improve health in Uganda.” MESAU envisions a future beyond current funding support. The question of sustainability of the performance outputs and outcomes, and of the partnership itself - because these are interlinked - is therefore pertinent.

Internationally supported projects have in the past been blamed for undermining local systems through fragmentation of services, vertical and parallel programs, compromised local control of health programs, and wage structures above the local prevailing rates for similar cadres. Together, these factors impact on the post-funding function and sustenance of affected local systems, underscoring the need to prepare local systems to be sustainable following the end of funding cycles. This process should begin with understanding the factors that are responsible for the success or failure of internationally supported initiatives. However, pinpointing these factors is not as straightforward as it seems. Multiple studies consistently report the lack of a single set of programme characteristics that are particularly responsible for either the success or failure of national public health initiatives. Neither is there a single set of factors (organizational versus personnel, public versus private control, resources, etc.) that is always responsible for the success or failure of collaborative initiatives. In view of this, and as part of the effort to ensure sustainability of MESAU, a decision was made to study the evolution of MESAU and document the factors that are likely to influence sustainability.

“Mapping the evolution and landscape of the Medical Education for Equitable Services to all Ugandans Consortium (MESAU)” fondly referred to as “The Mapping Study” aims to contribute to the success of MESAU...
by assessing and characterizing the processes that led to successful establishment and acceptability of the initiative among partners from multiple, diverse medical education settings in Uganda. By examining MESAU’s organizational, developmental and systems characteristics, an attempt is being made to bridge science and practice. Additionally the study acts in part as process evaluation which may encourage accountability among partners for progress in relation to specific, quantifiable objectives. This process also provides an opportunity to highlight the implications of the MESAU initiative as a mechanism for the integration and implementation of an important national health agenda.

First impressions
Early indications are that MEPI and MESAU are a welcome change to the conventional approach to internationally funded health-related projects and programs. A feature that comes across as being particularly favourable and desirable is the local ownership. Project activities were designed locally by the Uganda MESAU team to address problems that were identified locally. Additionally, the technical support that MESAU needs from northern partners is defined by the Uganda MESAU team, thus building a more balanced relationship with the US partner institutions. Another attribute that is perceived as being likely to enhance sustainability is that all accredited medical training institutions in the country are partners in the Consortium.

The inner workings of LOCOG and ODA have been satirized in the TV series, “Twenty Twelve” which follows the personal and professional challenges faced by the Olympic Deliverance Committee (ODC), the team responsible for delivering “the biggest show on earth”. In this comedy-documentary the ODC navigates through delicate issues such as how to handle the demand for a mosque in the Olympic village; how to carry out a sustainability audit when no one knows what it is; and how to deliver value for money where there isn’t any money. A major undertaking like MESAU is not different from the Olympics in that both create anxiety and uncertainty surrounding operational procedures and logistics, outcomes, projected impact and sustainability. With MESAU, there is a sense of anxiety concerning respective roles and expectations of the Uganda medical institution partners. This anxiety may be attributed, in part, to the apparent diversity in organizational culture across the five medical institutions, including the relative difference in structural and organizational capacity and perceived degree of ‘ownership’ of MESAU. Nevertheless, the appeal of this novel approach lies in MESAU’s mission to ‘strengthen country-wide institutional collaboration and to foster transformative, innovative medical education and research founded on strong sustainable institutional systems and social accountability’. Therefore it is anticipated that the anxiety related to the challenges of variability in institutional capacities will subside once the partners realize the benefits of the consortium.

The Head of Sustainability in the ODC wants to see sustainability embedded across all aspects of the 2012 Olympics, and she particularly likes to emphasise that, “sustainability is not legacy”. On the other hand, the Head of Legacy sees sustainability as an integral part of legacy. I totally agree with the latter view: MESAU’s legacy will be rooted in sustainability: sustainability of the partnership and sustainability of transformative medical education that is responsive to the health needs of the population. MESAU’s legacy will also lie in the ability to inspire the next generation of south-south and north-south collaboration and partnerships.

I leave the MESAU News readership with this enigmatic observation by the Head of Public Relations of the ODC in Twenty Twelve: “Guys we are where we are with this, and that’s never a good place to be.”

Leveraging Distance Learning Tools to Support the MESAU Mission

Mr. Dickson Muyomba, Dr. Ian Munabi, Mr. Edward Kakooza, Mr. Bob John and Dr. Bob Bollinger

In collaboration with the Johns Hopkins Center for Clinical Global Health Education, MESAU has launched a new Grand Rounds initiative to leverage distance education tools to expand access to clinical education in Uganda. The format for these sessions includes clinical case presentations, followed by a series of brief presentations and interactive discussions led by faculty experts on the clinical management and research updates related to the case. The sessions are broadcast and participants can participate in person, as well as via live video conference or on-line webcast. These sessions typically engage faculty experts and students from Uganda and from Johns Hopkins. For those unable to attend the live sessions, the Grand Rounds are also recorded and available later via the web. They are also distributed to all MESAU partner institutions via CD-ROM and digital files, which can be installed on the local institutional networks for students and faculty to view.

The inaugural sessions have been hosted by Makerere University College of Health Sciences, but all of the MESAU partner institutions have been able to access these sessions.
MESAU Distance Learning Committee is also working closely with all of the partners institutions to expand their own IT capacity to allow them to begin broadcasting Grand Rounds. The goal is for each of the MESAU partners to be able to rotate responsibility for hosting the Grand Rounds and to expand the number and scope of the sessions to a broad range of clinical topics.

To date, there have been six MESAU Grand Rounds sessions, since this program was initiated. The topics discussed included:

1. Central Nervous System Infections in HIV
2. Pediatric Cardiology Case Presentation for Hopkins and MakCHS First Year Medical Students
3. Prevention of Mother to Child HIV Transmission: Where are we now?
4. HIV-TB Interactions and Obstacles to TB Control
5. Obstructive Jaundice: An overview of the causes and management of obstructive jaundice in Uganda
6. Cervical Cancer: Diagnosis and Vaccination

These six Grand Rounds have been attended in-person, by a total of 363 faculty and students at Makerere University and by an additional 70 faculty and students at Mbarara University of Science and Technology and Kampala International University who viewed the programs via live webcast. In addition, CD-ROM recordings of these sessions have been shared with all MESAU institutions and have been viewed by an additional faculty and students. Finally, these sessions have been viewed an additional 398 times on the Hopkins CCGHE website. MESAU is developing a new web portal based in Uganda that will make these sessions and other educational programs even more accessible to faculty and students in Uganda and beyond.

The most recent Grand Rounds focused on Cervical Cancer (13 July, 2012) was an excellent discussion that included a case presentation by Dr. John Bosco Nsubuga of a 52 year old HIV+ Ugandan woman who presented with late stage cervical cancer. This was followed by an overview of cervical cancer epidemiology by Dr. Twaha Mutyaba, who reported that cervical cancer is the most common cause of cancer deaths among Ugandan women and that advanced cervical cancer is the admitting diagnosis for up to 80% of all of the women hospitalized at Mulago Hospital Gynecological Oncology ward. Edward Mumakech then presented data from the PATH program in Uganda, which reported excellent uptake of HPV vaccination among young girls (>80%) participating in a pilot project. Dr. Miriam Nakalembe presented an overview of the strategies in Uganda for cervical cancer screening and management. Final comments about the challenges to reducing cervical cancer incidence in Uganda were offered by Dr. Anthony Okoth Ndira. The remainder of the session was devoted to a highly engaging discussion among the participants about all of these issues.

This session and all of the MESAU Grand Rounds are freely available to all interested in these topics and can be viewed at http://main.ccghe.net/CCG/country/uganda.
The medical students of Makerere University College of Health Sciences working in partnership with TASO-Mulago, Dental school and Miracle Centre Church-Kireka, conducted a free medical camp for the residents of Kireka near Kampala.

By 8.00am on Saturday 21st July 2012, the grounds of Miracle Centre were alive with people seeking the free medical care courtesy of this rather unusual partnership. Over three hundred and twenty adults and children benefited from the free services offered. The services included dental, medical, cancer awareness and screening, HIV testing and counselling.

Many of the residents who turned up had lived with nagging conditions because they could not afford the fees involved, yet for others it was just ‘a stitch in time’.

The students were led by their president of the Makerere University Medical Students Association, MUMSA, Peter James Kitonsa, who emphasised that students can contribute even more to making health services accessible to people, while they are learning, gaining knowledge of the kind of communities they are to work in once they qualify and building their social entrepreneurial skills at the same time.

Partners played different roles with the students providing general medicine services, dental school doing extractions, TASO conducting rapid HIV testing & providing counselling, Miracle Centre Kireka provided the free venue.

Through partnerships like the one through which this work was done, the less privileged can access the much-needed health care.

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**Gulu University Medical Students Promote MEPI-MESAU Goals**

_by Emilio Ovuga, Gulu University_

If students at Gulu University’s Faculty of Medicine were individually asked what their priority in medical education was, all of them would unanimously declare their desire to promote the goals of MEPI-MESAU and be part of the transformation of medical education for the benefit of all Ugandans on equal basis. For reasons beyond the control of MEPI-MESAU at Gulu, it took long for the medical student body to receive a formal brief about MEPI and its objectives. When I finally conducted a seminar on MEPI-MESAU for students on 26 May 2012, the students unanimously said, “Now we know we are part of MEPI. We have been hearing about MEPI but we did not believe we were a part of it as no-one informed us.”

In my brief about MEPI, I described the strategic goals of the project and highlighted the key elements of the project with particular reference to northern Uganda; namely: a) promoting access to health services, especially in rural areas that suffered massively from the effects of the war that ravaged the region for over two decades and disrupted health, education, security and social infrastructure with at least two million of the population living in camps for internally displaced persons (IDPs), b) contributing to improved quality of health care by improving the quality of resources for student instruction and c) increasing the number of medical doctors in Uganda. Students listened to the one hour or so talk patiently and they were exemplarily attentive. When they were invited to discuss the presentation, students made a diverse range of extremely constructive suggestions and comments all of which collectively indicated a strong student commitment and support for the goals and aspirations of MEPI-MESAU; they requested that they be part of the planning process of all educational programs and work side-by-side with faculty administration and their lecturers. The students advised that lecturers at the faculty should be held...
accountable to the student body if they did not teach students in line with the terms of their employment.

In summary, the rest of the students’ suggestions according to themes; all fit neatly with a) the medical training program at Gulu University b) the goals of MEPI and c) the motto of Gulu University: “Community transformation”, as explained below.

Quality of clinical care: Students suggested to be mentored in clinical medicine using a variety of strategies including a tailored one week course in clinical learning during the first week of semester one in the third year. The students believed that this would prepare them for their clinical rotations during the third year. The students further suggested that student mentorship in clinical medicine should emphasize history taking and bedside teaching and demonstrations by their clinical instructors. This suggestion from students is particularly encouraging as the medical doctor in a rural health facility with no or inadequate diagnostic resources at his/her disposal has to rely on his/her clinical skills to elicit clinical evidence for planning appropriate and effective clinical care package for each client that presents to the health facility.

Research mentorship: Students suggested that they receive mentorship in research. They suggested that the Department of Public Health should teach research by involving students in active research than through lectures, and that, more departments than Public Health should be involved in student mentorship in research. The students indicated their interest in being part of research activities conducted in all clinical departments, singling out the Department of Mental Health. As a practical example, one student group has chosen to conduct research for its curriculum requirement on the mental health of students at the university in their bid to produce evidence for the need for mental health services for students following one incidence of suicide by a student at the University in May 2012. Students requested that the quality and scope of IT facilities at the faculty should be improved to enhance self-directed learning among students.

Transforming medical education: Students suggested that in order to enhance access to equitable health care in rural areas, the placement of students to rural health facilities should begin in the first year, and this should run through to Year Five of the medical training program. They requested that the quality of facilities at Gulu Regional Referral Hospital (GRRH) be improved to attract graduates to remain at GRRH after completing their internships. They noted that better facilities at GRRH would reduce brain drain and encourage the faculty’s graduates to remain either at the hospital or the faculty. The students further requested that the faculty should encourage its alumni to remain at the faculty to increase the numbers of its staff.

Increasing numbers of health workforce: The students requested that the quality of facilities at Gulu Regional Referral Hospital (GRRH) be improved to attract graduates to remain at GRRH after completing their internships. They noted that better facilities at GRRH would reduce brain drain and encourage the faculty’s graduates to remain either at the hospital or the faculty. The students further requested that the faculty should encourage its alumni to remain at the faculty to increase the numbers of its staff.

Student involvement: Students agreed that involvement of students in faculty administration, and program planning and implementation required that they give up the strategy of aggression, excessive assertiveness and avoidance of offensive language. The staff on the other hand need to be available to students as role models and mentors. They requested for regular meetings with faculty staff to ease misunderstanding between students and staff as a vital strategy to secure student support for faculty programs.
The Role of Medical Students in Community Transformation in an African Rural Setting

Pius Opejo (MBChB) Kampala International University

The day was 16th June 2012; the Day of the African Child, when Kampala International University (KIU) fraternity under the organization of medical students of KIU western campus braved a 3.5 km distance on foot from Kampa International University Teaching Hospital to Bushenyi Primary School Ruhandagazi, in Bushenyi District. The walk dubbed “walk for a disabled child” attracted a total number of 300 participants from different walks of life ranging from pupils, students, lecturers, religious leaders and politicians. Blue was the color of the day; all participants donned blue T-shirts, caps and ribbons.

Prior to the day students mobilized funds from charitable organizations, corporate bodies, university fraternity, and wellwishers. They also had talk shows on Hunter Radio and Television sponsored by the management of Hunter Radio and Television. This was aimed at creating awareness about disabilities and the need to show concern for the child with disabilities.

Celebrations for the Day of the African Child started in 1991 after initiation by Organization of African Unity in commemoration of the 700 children who were murdered in cold blood as they marched along the streets of Soweto Township in South Africa on June 16th 1976. They were protesting the poor quality of their education and the right to be taught in their native language. Since then, it is celebrated annually to raise awareness about the education of an African child as well as their rights.

You may be wondering why Bushenyi Primary School was chosen for the commemoration of the day in Bushenyi.

The school is a government funded primary school with a total population of 106 pupils; 2 physically handicapped, 3 epileptic, 20 deaf and dumb, 27 mentally retarded and 54 with learning difficulties. The school has 15 teachers, one of whom is completely blind. It is both day and boarding school but like any other UPE school, it has very limited funding yet surrounded by a poor community. It is located 3.5km north east of KIUTH along Ishaka-Bushenyi Road on Mbarara-Kasese highway. In line with this year’s theme; “The Rights of Children with Disability: Duty to Respect and Protect” Bushenyi Primary School Ruhandagazi was the ultimate choice for the celebration.

The day was very colorful and lively. Medical students, pupils, teaching staffs, lecturers, doctors and invited guests had a good time of bonding. They played various games, and had lunch together as a family. All people were de-wormed with Albendazole tablets, medical specialists screened the children for various disabilities and medical conditions, gave health education and appropriate referrals for some cases.

Among other things, the outcomes of this event, included;

• Over 300 people braved a 3.5km distance walk for the disabled child, a sign of good mobilization and community concern for the event.
• Over 100 people were de-wormed on that day.
• A total of 15 children, both boarders and day scholars got full sponsorship for their entire primary education.
• Three (3) new children were enrolled into school as a result of the talk shows.
• Parents of the children with disabilities received re-usable items and special skills and knowledge on how to care for children.
• Medical students and their staff had a day off from the demanding and stressful academic schedules and interacted with community members.
• The community members generally had a smile of hope on their faces and seemingly needed more of such events.

There were two key learning points for me out of this event. The first one is the need for medical students to get involved and contribute positively and actively...
Towards the development of their communities. The second one is in the form of a question: What is the Corporate Social Responsibility of the medical training institutions towards their surrounding communities and to what extent do they practice it?

They died young: A Reflection

Makerere University College of Health Sciences was last week engulfed in grief and mourning over the loss of two young students. July 26th Alice Nabukeera, (22), a third year student of Nursing died from a road traffic accident involving the infamous motorcycle taxis (Boda Boda as they are known countrywide). The previous day July 25th, Allan Mulalira, (21), a second year student of Medicine died one year after being diagnosed of leukemia. Several issues arise from these two premature deaths.

Firstly, as we struggle to build the health workforce, leakage from premature deaths due to different causes continues to be a menace in our environment and this must be addressed.

Secondly, these deaths are a stuck reminder that non-communicable diseases are a major challenge. We cannot turn a blind eye to their existence but we must generate the evidence on the burden of diseases attributed to them to help us build the appropriate health workforce capacity to address them. These deaths are not isolated occurrences but are part of the silent worsening epidemics of road traffic injuries and cancers in this country.

Thirdly, circumstances surrounding their demise and the health care provided (or not provided) are strong reasons for critical reflection and soul searching. The patients most probably could have lived on for some days if not months or even years if there were better health services throughout the country.

Fourthly, for sure the road traffic injury could have been prevented and this requires a multi-sectoral approach that involves engagement of among others, the public through public education, various sectors of government like legal, law enforcement arms like police or internal affairs, transport, roads and works, trade and industry, health and education. It is possible that the leukemia could also have been prevented but the facts at hand do not permit us to make a definitive statement. In a nutshell, these deaths summarise the task ahead for MESAU.

The fifth issue is that for meaningful change and improvement of people’s health, MESAU cannot do it alone but must create meaningful partnerships.

A sixth issue is that the struggle will have to be prolonged for years to come and hence sustainability of our efforts is critical. An essential part of this struggle is that the population must be made aware and come to believe firmly that health is a human right which is acknowledged in the constitution of the Republic of Uganda.

Lastly, a well prepared, well supported and well facilitated health workforce will go a long way in the realisation of this goal.
STUDENT PROFESSIONALISM AND ETHICS CLUB: A RAY OF HOPE

By Andrew Kazibwe and Jasper Nidoi (MBChB, Makerere College of Health Sciences)

‘A Head of knowledge, A Heart of Service!’

Imagine a world where all students attend all lectures, read up all the assignments they were given; do all ward procedures requested and even more; where they come back in the evenings to take their patients out for the walk they so desire; where students feel a debt within themselves of knowing and learning everything required of them. And all of this done with a smile!

Now imagine a generation where these students will be doctors, your doctors. I would gladly fall sick, knowing that my doctors will do their very best, irrespective of the circumstances, and will treat me as a human being, aiming to heal me biologically, socially, psychologically and spiritually; and not just treat me.

The Student Professionalism and Ethics Club (SPEC) is a student initiated and student-led club which will try and make that world a reality; to give students a platform, an arena to galvanize professionalism. In a world where patients are learning more and more about their rights and health from the internet and other media, ethical and professional conduct among health care workers is a prerequisite for a successful career.

With the support of MESAU and other partners, we hope to synergize efforts to create a more ethical and professional health care workforce. Thus far, a partnership is being built with MESAU to offer students an opportunity to participate in curriculum development (Defining competencies, developing and implementing an Inter-professional training model to develop competencies and skills in the realm of health professions ethics and professionalism). SPEC is also partnering with the different professional councils in Uganda to help students better understand what is expected of them after they graduate. SPEC has set up collaboration with the student academic clubs (Surgery Club and Medicine society) to emphasize the essence of ethical and professional considerations in patient case discussions. The club is also seeking to collaborate with the Uganda Ministry of Health, non-governmental organizations, patients’ rights’ groups among others to realize its vision of making Makerere University College of Health Sciences the fountain of professionalism in Uganda. In future, SPEC hopes to reach out to the different medical schools in Uganda so that collectively, we will see a fresh generation of medical professionals who put professional and ethical conduct at the forefront of their practice.

We extend our sincere gratitude, for the support thus far, to the College Principal, Professor Nelson Sewankambo, to our patron (Prof. Florence Mirembe), MUMSA and all students who have been kingpins in the activities so far held (the intellectual debate and essay writing competition).

The forthcoming semester shall see a number of activities including the Ethics Night, Intellectual debates, didactic lectures, essay writing competitions and student mentorship program among others. It is our heartfelt desire that MakCHS students shall find it a worthwhile experience to participate in these activities.

HANDS-ON LEARNING:
A YOUNG RESEARCHER’S EXPERIENCE

By Josephine Najjuma Nambi, Mbarara University

Excitement and joy filled the hearts of those students (now called principle investigators - Pls) who responded to the call for undergraduate students’ research proposals to MESAU, a Medical Education Partnership Initiative (MEPI) consortium in Uganda. In all, 60 awards each worth approximately 3,000 US dollars were awarded to 60 young/undergraduate research student multi-disciplinary teams across the 5 MEPI consortium medical institutions in Uganda. Those who did not participate citing hectic academic program (as the end-of-semester exams were around the corner) were buffered in surprise. But ‘what next’ was everyone’s question as the terms and
conditions seemed not clear to these largely inexperienced researchers. Consultative meetings were held with whoever seemed to have any knowledge about the MESAU/MEPI agenda including dedicated mentors and faculty administrators for details. Soon, we were ready to start the task as a team, dedicated to develop research protocol, seek relevant approval, collect and manage data properly and proudly write our maiden manuscripts for publication in a peer reviewed journal.

In the beginning everything seemed easy as the junior preclinical students (in first or second year) thought they were senior group members (clinical students in 3rd, 4th and 5th year) were conversant with the research process, but guess what? All members were welcomed to the new world of research in almost a similar way. Mentors ensured that we didn’t go astray and soon what seemed an uphill task turned to be so interesting and educative than we expected.

The group I headed set out to evaluate the effectiveness of the pre-community placement Leadership course in the Faculty of Medicine at Mbarara University of Science and Technology offered to 4th year Medical, 3rd year Nursing, 3rd year Medical Laboratory and 2nd year Pharmacy. This evaluation is a quasi-experimental interrupted time series (before and after the intervention – which in this case is the leadership course) where both quantitative (survey tools or questionnaires) and qualitative (focused group discussions) are used to assess the desired outcomes. The findings are expected to emphasize the significance of this course while highlighting the challenges, gaps and possible solutions hence producing better health care managers for this country. In an event of favorable results, recommendations will be made so that other universities implement the course.

The research process soon caught up with an un-suspecting PI (Yours Truly) when the mentor instructed her to fill the research protocol form and submit to Mbarara University Institutional Review Committee (IRC) for approval. I remember hesitantly asking “what is that sir” before he told me that I won’t be able to access grant funds without this. I remembered that in our work plan there was something like this, and I started recollecting that maybe it was due to this known that I won the grant! We only knew we needed ethical approval before interviewing participants but not a prerequisite to access the funds. I am proud to say that now I understand and I am able to prepare research protocols, get IRB approval, and make requisition for funds, the bureaucracy of meeting the finance managers and auditors, the patience of waiting for the cheque to mature, procuring research materials and making correct accountability for the grant funds under supervision. A hectic process, which I am proud to announce, that I was the first student to diligently accomplish. Salutations to the grants office, finance officers, administrators and above all, my mentor! I feel I am ready for my first appointment (job) and to the upcoming grant calls, I am the first beneficiary. Working as a team kept us going but as an individual, I am greatly indebted to MESAU/MEPI. The biggest lesson or challenge came when we started data collection. We used to believe that collecting data from an educated cluster of participants was relatively easy but we were wrong. Convincing university medical, nursing, laboratory and pharmacy students to fill a questionnaire without incentives! Lame excuses, initially claiming to be too busy for a 15 minute questionnaire was understandable in the examination period but this went to ‘how much do you offer?’, after the exams; more so during their community placements where we had to travel and meet them. We nearly regretted why we had not chosen to collect data from the rural community where the participants view research as a valuable step to influence the way of life.

Interestingly, I now serve as a “mentor” to other student PIs who are still along the research process as we all move on. The struggle continues.

She is mentored by Dr. Mugyenyi Godfrey of the Department of Obstetrics and Gynecology - MUST

Hard Work: A Pillar of Professionalism

By David Mukunya (MBChB), Anna Natumansi (MBChB), [Tony Orach, MBChB], Tadeo Kizza (MBChB)

It’s 6:30 am and all medical students are on ward, and don’t get fooled, there is no lecturer or faculty pushing them to be there. They are there to “pre-round”; to do a fresh exam, check vitals and ask their patients how they are. The last statement is “Hmm.. doctor its 5pm.” Not to mention that it seems our rotations are governed by A4 sized pieces of paper that we call signature sheets.

That is a ½ hour difference every day and by the end of a 2 year clerkship; about ½ a year in excess, which is almost an extra fellowship. With everything constant, which group do you think will be better at the art of medicine, with better clinical skills, and /or bigger knowledge base? Above all that, which group will be better prepared to sacrifice for their patients and clientele? I am not asking you for an answer, just requesting you to reflect about it. The ability to push yourself beyond your convenience, for something you chose to do, to work really hard at it even in the heart of difficulties, well aware that your patients may not remember you and your country may not appreciate. That is the true mark of a professional. It is what we owe Medicine as a profession and it’s what we sign up to when we start this path of standing in the way of any patient’s pain and anxiety.

As a professional, it’s your duty to be with as much skill and knowledge as your field has to offer; in short, a master in your chosen field. The only way to achieve this is to exhibit an extremely high level of hard work and diligence in all we have to do. Of course not to the exclusion of all else but to a level that is admirable not only to those around us but most importantly to our patients.

Imagine every day we added just 3 hours to our schedule as students, and in that time, we purposely put aside our signature forms and focus on learning something new; could be a clinical skill, a procedure or how to communicate with our patients. Imagine we dedicated ourselves wholeheartedly as our Yale counterparts do with hard work as our driver. Just imagine the difference it would make to our health system, our hospitals and our patients. It begins with you.
By Ismael Kawooya MBChB,
“No man is an island, entire of itself.”
John Donne (1572-1631)

The standard and integrity of Makerere University have been subject to public debate in recent times. Though often marked with accusatory tones, these debates and discussions have often yielded one solution; “major transformations”. These “major transformations” suggested have been argued to be key to the revival of this great institution.

Fast forward 2012; it’s almost a year since Makerere University fully adopted a collegiate system, a transformation involved no minor efforts. I however, have not heard any praises and matching band music to this effect. One is tempted to think its only criticism that this oldest university in Uganda attracts. I’m not an expert to delve into the benefits of the college system at the University, for I must apologize, I have kept my eyes and mind locked on Makerere University College of Health Sciences.

Turned into a constituent college of Makerere university earlier than the rest of the faculties in 2007, Makerere University College of Health Sciences has been the forerunner of transformation in the University. However, since I am not an expert in these matters, I beg not to go into the details.

Makerere University College of Health Sciences is situated on Mulago Hill, neighbouring vibrant Wandegeya town. The College is the oldest medical institution in East Africa and shares some premises with Mulago National Referral Hospital. The growth and transformation of this institution was not spared the “hard times” of the 1970s whose effects spilled into the 21st. At a time when health professionals seek more “soup” than is in their bowl, their professionalism has been brought to question. The “ill” status of our health care system and at times the “inhumane” actions of the health professionals has often been a favourite topic of media discourse. But before you point a finger in anyone’s direction first look at your back, you might need help with the giant tarantula leeching you out. The point is, no one is spotless clean and we need each other at almost all the times.

In spite of the picture painted, the health care system has not been labeled “unfit” to serve the population. One must wonder what then is still keeping us from being utterly “hopeless”. This drives me back to the medical institutions in the country.

Evidence of an improved health care system can be gotten from the commissioning of various health care professional education reports early in the 20th century including Flexnor, Rose-Welch and Gold mark. These reports led to dramatic changes, innovations and improvements in the health systems evidenced by the doubling of life expectancy in the 20th century all over the world. This growth was however distorted by the emergence of the HIV/AIDS epidemic and its effects in Africa.

Makerere University College of Health Sciences has enjoyed a number of innovations in an attempt to address the anomalies that exist in the health system in Uganda and the region. One should however not think of Makerere University College of Health Sciences as the lonely player; there are four other medical institutions that complement and supplement its efforts. These are Mbarara University of Science and Technology (MUST); Gulu University; Busitema University and Kampa International University.

It is therefore imperative to fathom that a partnership among the medical institutions shall be a lasting opportunity to correct any anomaly in the health care system. In the addendum “No man is an island,” John Dunne prophesized the importance of team work and partnerships to fostering development in any area. The importance of ‘difference’ is emphasized in any team, and what is brought to the table is always valuable for any positive progress to be made. Among the medical institutions such partnerships and informal working relationship have been established in one of the major transformative innovative grants won by Makerere University College of Health Sciences, together with other Universities with medical programs, from the US National Institutes of Health; the MESAU-MEPI (Medical Education for Services for All Ugandans- Medical Education Partnership Initiative).

At the centre of this grant is the training of students mainly the undergraduates whose skills and competencies have to match the needs of the health care system. I asked a few former students of the Makerere University College of Health Sciences what they thought about this relationship, particularly on working with students from other medical institutions and if they thought medical education prepares them for the challenges of the health care system. Below are their opinions;

“A unique blend of education systems for the health care systems is presented and this provides a good dimension in approaching the different challenges. Therefore working together with other students makes it certain that we provide the best.”

“I think it’s a good thing to work with students from other universities as it provides an opportunity to share knowledge and experiences given the differences in the way we are trained i.e Problem Based Learning versus the traditional lecture system. I think medical education prepares me well for the health work force in Uganda as I get enough contact with patients as a student and when I start to work as health personnel I am well prepared to practice medicine.”

“When I was a medical student doing electives, I found the Gulu interns very good surgically and socially and good teachers. Mbarara interns were also good teachers but not as good socially.”

“They are cool by the way, am with two doctors from MUST, but just like those with life experiences of Mak, they also offer what they got.”

“Our medical education is grossly lacking in the area of Health care Management and Computer Information Technology” These viewpoints provide a contrast to how Makerere University College of Health Sciences students perceive working with students from other universities. They paint a graphic picture about the probable future of health care system. Students, though not yet integrated into the health care system with liberty do provide a bench mark for tomorrow, if handled very well, will be the needed agents of change of what has now become a major transformation into the health care system and education.

MESAU-MEPI provides this unique working relation and although they have previously worked together on the Makerere University Medical Students’ Association conferences, other activities are needed to cement this working foundation that will uplift the face of health care practice.”
June 6th-8th 2012, delegates from all MEPI institutions converged at Stellenbosch University in Cape Town to share experiences, innovations and forge a collective effort to steer MEPI in the right direction. This is in an effort to deliver the best for the aspirations desired in addressing the global health workforce crisis in Africa.

In this issue we take an opportunity to share, in brief, some experiences and innovations that have been brought forward by different MEPI institutions in addressing critical concerns in improving quality of medical education.

i) Evolution and Implementation of the CBE Curriculum: What is the best Methodology?
Using a non-traditional (unaided) presentation approach, Professor Iputo Jehu of Walter Sisulu University –SA, clarified and emphasized the critical need to evolve competencies in the true context of the needs of a particular locality. He said there is limited benefit in generalizing curricular competencies! The way forward is about addressing the uniqueness of our local communities, customise the curriculum, and train accordingly, deploy and evaluate the impact.

ii) E-learning /Technology Assisted Education: A Living model, Next Door, In Tanzania!
Ms Lucy Kilewo (an e-learning Management System Specialist at Kilimanjaro Christian Medical University College) narrated her experience based on her tested model of e-learning. E-learning is a proven tool in meeting the Medical Education students’ needs in the midst of limited resources. The benefits experienced include: a) Large classes can easily be handled, b) The ease to reach and train distant learners. c) The ease to access latest research information, d) Students are taught and assessed on-line, e) Students quickly adopt and demand for on-line instructions.

The challenges experienced so far with e-learning include: a) Hardship in accessing the needed course contents, b) Students accessing inappropriate content c) Poor adoption and resistance to change from the traditionalists.

iii) Skills Lab Development and Applications as Practically Established at Stellenbosch University.

a) Biomedical and clinical Science Labs:
The traditional set up and utilization of the Science labs is disbanded. Present are computerized set ups to demonstrate the structure and functioning of body systems (like the heart and the rest of the CVS) with control points along the entire system. Under wider collaborations, the skills labs are open to use for trials of Pharmaceutical companies for chemistry and therapeutic trials on diseases like Cardiovascular Disease, Diabetes Mellitus etc. This fetches an income and is another way to sustain and further develop the skills labs. The Anatomy skills lab is more of a Museum which has a wide variety of prospected models preserved under transparent glass containers. There are embryological specimens depicting human embryo and fetal formations, as well as congenital malformations (like the Siamese Twins, Anencephaly, etc.). The exchange of Examiners and Lecturers adds great value in introducing variety of skills and innovations to the skills labs. Since 1973, this Museum attracts tourists which aspect generates income for the maintenance and development of the Anatomy skills lab.

b) Clinical Skills Lab: It’s now 8 years old having started like a lab for general use, but now it’s turned into a MUST use facility. It provides alternatives to ethically restricted human subjects i.e. artificial models for the trainers and the learners. The set up is according to the Medical curriculum and it’s managed by a Nursing Officer but training is carried out by specialists from different departments. All practical manipulations on the human body (Injections, infusions, catheterization, specific punctures, aspiration, etc.) during training are done using artificial human anatomical models.
Planning for sustainability

By MESAU Secretariat

We are near the end of the second of a five year US government MEPI funding grant to support MESAU programs. This funding has created excitement and generated a lot of very promising initiatives in five Ugandan universities that are beneficiaries of this grant. No one knows what the future holds after the current funding cycle. A major challenge therefore is how to sustain the excellent efforts initiated and which give promise to addressing the longstanding enigma of inadequacies of medical education and health workforce in the country. We share some thoughts on what should be done to work towards ensuring sustainability. We are prepared to mobilize and engage all stakeholders so that MESAU efforts continue and even surpass the current levels well beyond the end of MEPI funding.

1. Value for money

For any individual or organization including government that may be attracted to invest in MESAU activities will be interested in getting value for money. Through monitoring and evaluation we have to show our outputs and both the intended and unintended consequences (outcomes and impacts) and especially regarding improvement in service delivery and people's health. We have to maximize returns on investments through enhancements of efficiencies and effectiveness based on careful consideration of how and on what every dollar invested is spent. Ensuring value for money is a strategy that runs a good chance of attracting funding and other forms of support towards MESAU activities.

2. Country ownership, leadership and stewardship

MESAU is a homegrown initiative lead by Ugandans and serving the people in Uganda within the wider context of the national health system improvement and development. Our universities cherish the in-country and outside partners but country ownership and leadership are vital for sustainability of the transformations that characterize MESAU. Our efforts should be bolstered by in country mechanisms that demonstrate a deep rooted commitment to country ownership and leadership. The country needs to regularly review and define health workforce needs and priorities as a nation to which MESAU can respond appropriately. For this response to be well aligned, the universities, and with support of the public and private institutions will translate these into educational needs and appropriate programs. External funding and other support are a necessary but insufficient pre-requisite to successful implementation and sustainability. It is also inconceivable that MEPI funding will be with us for decades to come.

3. Innovative Domestic financing and other forms of support

Health is a human right and the government of Uganda is committed to ensuring that its citizens access quality services irrespective of where they live in the country. This commitment must translate into meaningful government budgetary allocations to support educational and research activities geared towards improvement of health service delivery. The public should contribute to a discussion on ways that government can use to mobilize the necessary resources for this purpose. Tokenism will not serve the intended purpose. Whereas initial investments may be modest there should be a clear plan for a gradual increase over a period of time. Various stakeholders throughout the country and including the private sector will be mobilized to support MESAU in various ways and will receive appropriate recognition.

4. Partnerships and shared responsibility

To achieve a healthy population requires an approach that emphasizes a shared responsibility among all stake holders. Equally true in our environment is that to ensure quality medical education which contributes adequately to production of enough health workers requires an approach that emphasizes a shared responsibility. Mechanisms need to be in place to mobilize and engage domestic and international partners, from village health committees to parliamentarians, from local community to top government leaders and from small local NGOs to international funders and so on. Engaging international partners will assist in diversification of international funding support and access to outside technical support.

5. Strengthening the Consortium approach

Whereas the MESAU consortium approach may well fit under partnership and shared responsibility it is so important as to deserve its separate consideration here. The coming together of the medical education institutions in the country is a move that is poised to contribute substantially to sustainability of our efforts. Together we have a national medical education platform, remain well coordinated in our efforts and have been able to approach government departments as a group, hence delivering clear coordinated messages. There is an appreciation already of the benefits accruing from working together, creating synergies and maximizing efficiencies. We shall examine all possible ways of making this consortium approach stronger and stronger.

6. Advocacy

It is unlikely that the above can be achieved effectively if there are no effective advocacy platforms. The public, government departments, the private sector and funders all need to understand what MESAU is about, what gap it is attempting to fill and what its needs are.

It will be a pity if after the end of MEPI funding we will not be to sustain the great efforts that we are all proud about so far.
The value of student mentorship has been widely recognized. Mentorship is a helping relationship, based on encouragement, constructive comments, openness, mutual trust, respect, and a willingness to learn and share. The relationship is made between an expert (a more knowledgeable and experienced person) – mentor and a less experienced employee, teacher or student – mentee. Mentorship is important because success does not depend on academic knowledge alone, but also on understanding the organizational culture, social skills and values.

Several years ago an attempt was made to develop a student mentorship program at the then Makerere University Faculty of Medicine. Such efforts were not sustained due to several factors such as lack of mentoring skills among the would-be mentors and lack of appreciation of its importance among the mentees. Concerned about how the students were coping, a situational analysis of mentorship at Makerere University College of Health Sciences was conducted. Subsequently, in April 2012, the MESAU-MEPI collaboration, recognizing the need for student mentorship requested the authors to take on leadership roles in developing an effective Student Mentorship Program. To this end a Mentorship training workshop was held on the 11th April 2012, attended by 30 faculty members and 30 students.

Mentorship was comprehensively defined and its benefits to the mentee, mentor, institution and society were elucidated. The roles and responsibilities of both the mentor and mentee were clarified. Attributes of an effective mentorship program were discussed. Mentees were matched with potential mentors of their choice. Thereafter a workshop report was presented to the MEPI-MESAU meeting and later to the College management committee. The proposed plan to establish a student mentorship program was endorsed. The college committed to assign the role of Mentorship Coordinator to one of the School Academic Registrars and to support a continuous mentorship training program for faculty members and students. Such training will be run monthly. An interim mentorship Advisory Committee was established comprising of the three authors of this article and a recently graduated medical doctor, Ismael Kawooya. He will be working closely with the mentorship coordinator. As soon as the coordinator is identified and assigned, a call for interested mentors will be put out by the office of the Principal.

It is very exciting to know that soon a fully fledged Student Mentorship Program for Makerere University College of Health Sciences will be operational. Monitoring and evaluation of the program will be performed on a continuous basis. All forms of help and advice will be highly welcome.