Narrative of the meeting held on 19th April 2008 at the Phisiology board room

Note: This narrative was written during the meeting. It may not be fully detailed and comprehensive, however, it provides a good insight on what was discussed on that day. Mintues were written along with it.

Dr. Mwanika, 9:09

- welcome to the Hon. Minister
- Talked about changes that have occurred. The revolution, doing problem-based learning.
- Three points have led to the changed: decentralization in 1995 placing responsibilities on to districts. MISS did an assessment of the decentralization and found a lot of problems. A feasibility by the faculty of Medicine in 2002 found that graduates were clinically proficient but no people skills, PHC low, administration/mgmt problems and willingness to locate.
- The curriculum was thus changed: One of the tools adopted is COBES.

What COBES is not: It is not a subject, it is a strategy, a tool for achieving a number of goals and objectives.

Objectives:
Because it locates students in rural districts year 1-4 for 4-6 weeks, it prepares students for the rural community.

It integrates reality health programs into the training. With regard to MoH, there is need to integrate ministry priorities into the training, acclamatise students to the rural setting, align students to health needs. When students go out into the rural community they perform activities in homes, schools, communities, thus coming into intimate contacts with the real needs of the people.

COBEs is being used to change the locus of health intervention. Students have home-based assignments and activities. COBES provides students with authentic learning environment. Life is unstructured, students deal with real life. The environment in which you teach and learn should be closely related to the environment of work.

COBES Motto: Train health workers in the communities that they will serve.

COBES is currently developing a portfolio that will drive the assessment of students in the community, thus driving learning. Need to in build assessment requirements in activities. This is done using the portfolio.

Service provision: Promotion of PHC and Family Medicine. They are part of the COBES program, core to the COBES program. Health sub-districts were set up with the plan to promote family medicine.

When students go out, attendance goes up by 30%. This is further improved by them going to schools and home. Students spend more time with their clients. Example: Students tracked clients PLWHA to their homes and spent a lot of time with time and found many flows, i.e. students did not have proper drug medication knowledge. All drugs in one paper bag. Taking drugs without following prescriptions. Staff at the facilities do not have the time to properly explain issues to their clients.

Service penetration: While everyone talks about, the students actually achieve it when they take services to the grassroots.

ACHIEVEMENTS:

- COBES in 43 districts of Uganda since 2003.
- A high level of acceptance of the COBES program students.
- Students in their second year conduct community diagnosis to identify a community based health project the basis upon which they write a proposal to execute as a project in year 4.
- Partnerships that COBES has been able to attract, e.g. MIFUMI which contributes mainly by manpower. COBES has manpower that is willing, dedicated and committed. AIM, NUMAC, UPHOLD are further partners.

PROJECTS

Students do a malaria project for example and want misquitoe nets distributed. Kalisizo students project; a deworming project in Wakiso; health education talks, sanitation improvement (cleaning), increasing awareness of STI, etc. (Request for Dr. Mwanika's presentation).

CHALLENGES

When students are sent out to the districts, they go with curricular objectives, service objectives etc. They have a problem with accessing learning materials.

Supervision is also a problem. Site tutors are very busy with high turnover.

The COBES team would have loved to spend time with students in the community and while there use available resources to perform critical treatment / operations.

Student's welfare: When out there, where they sleep, how they eat, transport etc.

POSSIBLE SOLUTIONS

Set up resource centers in the districts with a library, 10 dormitory rooms, recreation room. In these centers we could place Internet connections for use by doctors, district health workers, pupils, students etc. A platform of eLearning. This could be done through development partners and the district.

Portfolio issue / family medicine: The program here has very low intake, yet the family medicine practitioners are need to be engaged at the district level.

Allocation of student training in district budgets for COBES students welfare.

Government needs to do something to include COBES activities in the student's fees structure.

REQUEST to the MINISTER:
Champion the policy for COBES to become a national training policy. COBES can benefit the training of students in the community. For example MUK presents 30,000 students who can potentially provide service to the community. Development partners, e.g. DFID cannot even support COBES programs due to lack of a national policy.

CONCLUSION

COBEs has high potential. The skill shortage issue in the health sector is an outcome of poor education all over the world, which is not in tune with the reality. Turn round education through COBES to introduce real life education. Link up students curriculum with community based education and services as a policy.

With a policy in place, we can roll out the program to all tertiary institutions.

Finally, there is a huge man power resource. If required through a curricular activity to go to the community and provide service, this will be successful without a national fall out.

Hon. MINISTER's RESPONSE:
There is no doubt that this is the real program that we should have thought about thirty years ago when Almata declaration was made regarding PHC as a strategy for providing health care to the people. As Archimedes said, Eurake, you got it. Linking training to service provision is an important aspect that could be rolled out in Uganda and even to other countries.

I must take this opportunity for thanking MIFUMI for working hand in hand with MUK. Health cannot be achieved single handedly. I am excited that you have directly brought me on board as the consumer of your graduates. We do not train at the Ministry, but we consume the products that come out.

I now really appreciate the key role that must play. First of all in making my technical people appreciate this as a program. I will with time invite you to come and make a presentation to the Health Policy Advisory Committee. This committee involves not only MoH technocrats but also other stakeholders. I will also talk to my collegues at MoE to see how to bridge up the interlinkages. Education / Health doing their own things does not help the opportunities we could exploit as partners.

It is now coming to five years since COBES inception. An evaluation is probably necessary. Makerere started community education for only fourth years, but a few years ago they started expanding on community based training and the level of acceptance is amazing.

Usually after graduating, impact is no longer felt. A quick follow up is necessary after graduation to see how many graduates are actually willing to go to the community. Most may want to remain in the city where 80% of the doctors serve 12% of the population, leading to inequity in health service provision. It is important to see how the graduates appreciate the training and are willing to relocate to the community. E.g. Mbarara, all HC IVs have no doctors, they do not want to go to that level of care, to the extent that the Ministry is beginning to think maybe they brought a wrong strategy.

The Ministry is even thinking of a new strategy like task shifting. May be since the doctors do not want to go to lower health centers, train clinical officers to do some of the services that doctors could do there, e.g. performing caesarian sections, hernias, blood transfusions etc.

I would like to encourage students not to follow suit in the foot steps of other who have not gone there.

Continuous assessment: Students participate in the various activities, but students are always obsessed with passing exams, and this would underscore the assessment, however, how does this relate to the reality on the ground. The level of enthusiasim, does it remain.

Another issue is the need for family medicine practice at the forefront. As an internal matter, it is currently practice that seems to be despised, even in the medial fraternity. E.g. asking collegues: What are you? How can we make family medicine be appreciated as a practice that can make us deliver quality care to our people. We need many more family practitioners. Unfortunately for the past five years since the inception of family practitioning, there is instead a downward trend. There is need to revump this practice, bring it at the forefront to help us deliver care.

With these few remarks, I would like to end here and get a few responses. I assure you that I will specifically ask my technical people to meet you. I will also discuss this program with my collegues at the MoE and Sports, as it will help us achieve MDG and Health for all in Uganda.

Dr. Mwanika:
Ministers question: How would you want the district to fund student activities? The funding approach will call for many authority centers. May be the budget should be centralized at COBES to reduce authority centers. Otherwise it becomes difficult for the district to budget.

The other aspect the Minister appreciated: Instead of engaging other partners to deliver services to the community, it is important to engage students to deworm, distribute mosquitoe nets, etc.

Presentation by Nelson on work with MIFUMI:

Students design tools to be used for educating people on health issues brining on board their interpretation of the tools.

Students design ICT health interventions that are relevant to the end users and contribute toward improvement of health in Uganda.

Tutorials were designed in partnership with MedLine Plus. Collaboration between NLM, USA and Faculty of Medicine etc. It is cross cutting – request for presentation from Nelson.

The tools is mainly visual aid, e.g. relating a pregnant mother with malaria related to a coffin. Pupils can then be used as an ambassador to communicate that it is not good to get malaria when you are pregnant.

The tools is translated into many languages, lukiga, luganda, luo.

Dr. Ibingira, Deputy Dean (Research)
Requested that the Minsitry gets closely linked to the Faculty of Medicine. It is difficult for the Faculty of Medicine to break through to the policy committees to influence policy.

He requested the Minister to put in his program time to interact with the Medical school and suggest opportunities for strengthening collaboration and improvement.

The biggest issue currently is sustainability of the COBES program. How can the Ministry come in to help with sustainability. It is a very big problem.

COBEs is even considering asking parents and students to see how to best sponsor the program, yet MoH and MoE can greatly benefit from this initiative.

Hon. Minister:
When people understand what you are doing, they begin to appreciate it and become part of it. My first initiative will be to organize for you to make a COBES presentation to various people who matter, e.g. HIPA, Members of Parliament of the Social Services Committee. I will specifically request the Chairperson of the Social Services Committee to meet with the COBES program and where possible see way of allocating a budget.

Regarding research, it is two way: This should be the beginning to keep on relating with the Faculty of Medicine. However, when research, please gear it toward addressing the problems that we have, and endeavour to disseminate research findings. Put research finding in a language the lay people / policy makers can understand and translate into policy and tangible activity. The first intention of researching should be to help us solve the problems that we have in our setting.

Discussion on partnership:

Development of a Gender Based Violence Curriculum

The working group consists of the following members

- Atuki
- Dr. Ssali
- Henry Oboke
- Annet Kutesa
- Oj
- Simon

Cause a meeting by latest 15th May 2008

Development of a Health Informatics Curriculum

Julia would like to think of whether the curriculum comes before or after the Health Informatics Center.

Procedure of proposing to introduce a Health IT Curriculum

Julia: Will the faculty board see this as a package?

Dr. Isaac: The curriculum is currently under review and this would be an opportunity to include it as a course. One possibility is to integrate the IT curriculum as a course offered by the faculty.

Ronald: If the Health Informatics curriculum is to introduced in the COBES it would be very short.

William: For a start, parts of it could be integrated in the COBES program. The long term objective is to have Medical Informatics as a course at Masters / PhD level.

Julia Royall: Right now, people need to be trained in searching database. This requires priority. Mandatory training in searching databases. Googling for medical information is not really the thing. It is difficult to get round things without doing proper MedLine search.

Isaac: Thinking about the bigger curriculum, there is still need to start small.

Julia: there are two important themes: learning how to search databases and creating tutorials. The strength is that the ideas of the courses come out of the work in the COBES program and we figure out how to best do it.

Isaac: We should explore the possibility of training first year students.

Ronald: To create the emphasis, it should be something able to fetch some marks, so that students take it seriously.

Julia: Informatics can play a key piece in taking professionals to the community. There is an assumption that Uganda is not a good place to be.

OJ: Nigerian communities require medical professionals to go to the community and offer service for at least one year.

Ronald: Suggestion that Julia takes it up with the Deputy Dean and we keep following it up.

Julia: This input is so helpful, i.e. contributions from the team.

Isaac: Isaac has offered to go with Julia.

Simon: An entry point could be to use the six weeks provided to COBES by first year students to teach on relevant IT components.

Julia to meet with Simon in MIFUMI.

Task: Julia to meet with Isaac on Thursday, 17th Apr 2008 to meet the Deputy Dean and discuss this possibility.

Deborah: The datasets in the centers could be used for the portfolio assessment. The whole idea is to have computer / Internet access at every COBES site.

Isaac: MIFUMI has been included as one of the 20 COBES resource centers.

Domestic violence referrals:
This should also be handled by the team going to work on the GBV curriculum and feed back to be fed back to the COBES partners.

Promoting training, research and IT
There is need to explore "Continuing Medical Education – CME" and the bandwidth being rolled out by Ministry of ICT.

There is a project on the interconnectivity of districts by the Ministry of ICT.

Also the Health Resource Center by Dr. Mukooyo.

The Ministry of ICT is also trying to make laptops accessible to civil servants.

Three things: CME / CPDE (Continuing Professional Development and Education), Resource Center and Ministry of ICT.

Task: Andrew, Simon and Julia to organize and meet Dr. Mukooyo. There is also need to get hold of Andreas of the Catholic Medical Bureau.

William:
A component could be integrated in eHMIS to enable students to send information back to the COBES headquarters.

William also happened to work with a gentleman who does Phone and Health Information. He met a gentleman designing a software that can send information from the community back to the center and vice-versa.

Task: Willaim to link the gentleman in Stanford university with Isaac Okulo to discuss the mobile phone software he is development.

The challenge being addressed is how you get information from the community to the central location to allow for information sharing.

Strengthening leadership and management:
Isaac: There is a small committee developing this at the Medical Faculty. Isaac to link this agenda with that committee. This has already been piloted to COBES sites.

Wealth for Health
Task: There is need for COBES to rekindle contact with NAADS, identify pilot districts and ensure MIFUMI is one of them. This to be done by Dr. Mwanika, Ian and Deborah.

Addressing political mileage
Task: Need to work toward Dr. Otala's commitments. Endeavour to meet to the Minister at his office next week. – Dr. OJ to take care of this.

Committees:
- IT: William
- Political mileage: Ronald, Brian and Nelson
- GBV: Deborah
- Wealth for Health: Deborah and William

Other people who need to be addressed are: The Association of District Chairpersons. Also the Dean Medical School could explore the involvement of Prof. Bukenya.

Task: Consider organizing for Kenya students to come to MIFUMI between 12^{th} – 16^{th} May 2008. Lobbied by Ronnie. Lobbying for accommodation, upkeep and transport.

Dr. OJ: PSMP (Positive Self-Management Program): Training HIV positive people. It was evaluated over five years. Training was done with a group of people in Nairobi. Over the years, facilitators and tutors have been trained. After the pilot, an evaluation was done at community level and the impact at the rural community presented amazing results. Other people interested in join it as facilitators could get the opportunity to know how to improve on the lives of people who are LWHA.

In the HIV conference it was clear people do not go for HIV testing. This has changed among PSMP clients. A positive response was noted. The solutions are from among members advising each other. PSMP has funding from Elton John foundation and intend to spread out the program though out Africa.

COBES could explore how students could possibly benefit from the PSMP program.

COBES about the power of the youth.

Date for the next meeting:
Wednesday, 4th June 2008