



Enabling Faster, Better care  
amidst the  
Global COVID 19 Pandemic



**walimu**

Annual  
Report

2020





## Cover Picture

A clinical skills session at Gulu RRH  
Pediatric Ward

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# 1.0 Our year at a glance

## Performance Area

### Patients touched

2020	4851
Cumulative	12704



### Health workers trained

2020	811
Cumulative	1212



### Care-givers for children trained and followed up

2020	2808
Cumulative	4388



### VHTs trained

2020	1478
Cumulative	5911



### Health Facilities

2020	47
Cumulative	78



### Districts

2020	18
Cumulative	33



### Projects

2020	11
Cumulative	18



### Publications and conference presentations

2020	2
Cumulative	5



## 2.0 Where we are



Programme	Location
Health Systems strengthening for Epidemic Preparedness and Response	<ul style="list-style-type: none"> <li>• Arua Regional Referral Hospital</li> <li>• Gulu RRH</li> <li>• Lira RRH</li> <li>• Soroti RRH</li> <li>• Moroto RRH</li> <li>• Mbale RRH</li> <li>• Jinja RRH</li> <li>• Naguru RRH</li> <li>• Mubende RRH</li> <li>• Hoima RRH</li> <li>• Fort Portal RRH</li> <li>• Kabale RRH</li> <li>• Mbarara RRH</li> <li>• Masaka RRH</li> <li>• Bundibugyo Hospital</li> <li>• Rwebisengo HCIV</li> <li>• Bwera Hospital</li> <li>• Arua District</li> <li>• Terego District</li> <li>• Madi Okollo District</li> <li>• Isingiro District</li> <li>• Lamwo District</li> <li>• Adjumani District</li> <li>• Moyo District</li> <li>• Kikuube District</li> <li>• KCCA</li> <li>• Wakiso District</li> </ul>
Smart Triage	<ul style="list-style-type: none"> <li>• Jinja RRH</li> <li>• Gulu RRH</li> </ul>
Smart Discharges	<ul style="list-style-type: none"> <li>• Mbarara Hospital</li> <li>• Holy Innocent Children's Hospital Mbarara</li> <li>• Masaka RRH</li> <li>• Jinja RRH</li> <li>• Mbarara RRH</li> <li>• Kisiizi Hospital</li> <li>• Nyakishenyi Subcounty, Rukungiri</li> <li>• Nyarushanje Subcounty, Rukungiri</li> <li>• Entire Gulu District</li> </ul>
ARCS	<ul style="list-style-type: none"> <li>• Kiruddu National Referral Hospital</li> <li>• Hoima RRH</li> </ul>
Integrated Family care	<ul style="list-style-type: none"> <li>• Jinja RRH</li> </ul>



## 3.0 WALIMU in Brief

**World Alliance for Lung and Intensive Care Medicine in Uganda (WALIMU)** is a Non-Government Organization (NGO) led by physicians from Uganda and the United States that works to improve clinical care for severely ill patients in hospitals across Uganda. WALIMU was established and registered in United States as a 501(c)3 non-profit organization in 2010 and registered in Uganda as an NGO in August 2013, with offices in Kampala. WALIMU's programming model is built around behavior change interventions that target the essential conditions for improving the quality of health care provided. WALIMU's Project portfolio includes both research and non-research grants. For the research grants, focus is on implementation science likely to transform patient care. WALIMU currently works in five thematic areas;



- Reducing mortality of children presenting with Severe Infection through testing and implementing interventions to improve triage and post-discharge care
- Using Implementation science to improve detection, diagnosis and management of Tuberculosis
- Improving Integrated management of Non-Communicable Diseases at Primary Health Care level through capacity building initiatives
- Driving the policy agenda on Sepsis through generating evidence
- Improving facility and community level capacity in quickly detecting and effectively responding to diseases of epidemic potential

## Vision

To reduce mortality amongst severely ill patients in Ugandan health facilities.

## Mission

WALIMU works to empower health workers to address local health problems in innovative ways in order to transform patient care and improve outcomes.

## Core Values

1. Evidence drives our work
2. Excellency in all we do
3. Innovation in addressing local health problems
4. Integrity in our dealings
5. Partnership for greater reach and impact



## WALIMU

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## 4.0

# Message from the Executive Director



Dr. Nathan Kenya-Mugisha  
**Executive Director**



**T**he Global COVID 19 pandemics has given our health system the biggest test in modern times. With the pandemic out stretching the available human resources and infrastructure, the need for faster and better care has been more required than ever in 2020.

Amidst these challenges, WALIMU's role in improving capabilities for facility and community level preparedness in detecting and responding to Severe Illness has been more pronounced than ever. Using our Health worker First model, we have enhanced our interventions to ensure that the health worker has the requisite knowledge and skills coupled with modern tools to enable function. We have continued to uplift work environments for the health worker in the area of triaging at the health facility, providing optimal care for hospitalized patients and preparing the patients for post hospitalization support to ensure full recovery. In 2020, we have appreciated that the care loop is not complete without the VHTs. Our program model has expanded to have a more pronounced role for the VHTs being the first point of contact with the health system especially in rural communities. With Health facilities now also referring downwards to the VHTs for follow up, we now have

empowered VHTs which has further enhanced our Community Based Disease Surveillance program. Our research work on Sepsis has been a reference point in generating more evidence on diagnosis and therapeutics for emerging diseases including COVID 19 which we hope will improve care for patients with Severe Illness.

Internally, we have maintained a threefold annual increase in grant income. This has necessitated realigning our internal systems especially the human capital component which has seen our headcount double this year. In 2021, our focus will be on extending our health worker first model to our internal systems to ensure that we attract and retain the best talent to further our mission.

We are grateful to our partners both in-country and external especially the Ministry of Health who have been instrumental in achieving our mission in this very challenging year and look forward to further strengthening our collaborations in 2021.

Dr. Nathan Kenya-Mugisha  
**Executive Director**



## 5.1 The Global Health Security Agenda: Enabling functional triage and timely case detection of Diseases of Epidemic potential

Findings from the Global Health Security Index survey published in October 2019 indicate that National health security is fundamentally weak around the world. No country is fully prepared for epidemics or pandemics, and every country has important gaps to address. Uganda's rating for early detection and reporting for epidemics of international concern was at 50.2%. Prior to the COVID 19 pandemic, our focus was on facility level preparedness and response through enhanced triage systems and the clinician's role in disease surveillance and reporting. While this made strides in quickly detecting and effectively responding to Viral Hemorrhagic Fevers, with the onset of COVID 19, we have had to move to the community through enhanced community and events based surveillance.

### **5.1.1 Building capacity of RRHs and providing tools to quickly detect and ably treat Severe Illness**

The onset of the COVID 19 pandemic found WALIMU already implementing interventions in improving detection of EVD in high risk areas especially boarder and Refugee hosting districts where

there was high risk of importation of the virus. As part of enhancing community case detection capabilities, a Community Based Disease Surveillance system, was set up in the then Arua District (Including Madi Okollo and now Terego). This involved skilling 200 VHTs within the refugee settlements with skills in comprehensive disease surveillance, providing them with the necessary tools for reporting and following them up to ensure behavior change. In the VHT dialogues held, the impeding factor in having sustainable community level surveillance is the unavailability of the monitoring tools to the VHTs. In liaison with the Surveillance Department, efforts are underway to collaborate with partners like UNICEF that has been distributing monitoring tools. On the side of health facilities, clinical teams from the refugee hosting districts of Lamwo, Adjumani, Moyo, Arua, Kikuube and Isingiro were trained mentored in identifying suspect EVD and SARI patients, triaging them and providing adequate clinical care with the necessary Personal Protection Equipment. 170 health workers were drilled in clinical case management and were able to enhance the District Rapid Response Team activities in their respective District. The onset of COVID found these districts with human resources that were able to quickly transform into case management teams.

The COVID pandemic necessitated a quick transition from preparedness to response. In collaboration with the World Health Organization and the Ministry of Health, onset of the pandemic necessitated having a pool of clinicians, competent enough with the requisite skills and tools to battle the pandemic. In the community, there was need to have a knowledgeable community, able to identify COVID suspects and refer them for appropriate management amidst the risk of stigma. In the health facilities, there was need for an enhanced functional triage that could detect COVID suspects such that they would be separated from other patients so as to minimize health worker and cross infections. The uniqueness of Kampala and Wakiso brings in special challenges in the delivery of health services. Kampala's day time floating population of about 4 million persons necessitated setting up of community surveillance through the Village Health Teams. A critical mass of 751 VHTs from slum areas and immigrant settlements in Kampala and Wakiso were trained in CBDS with a focus on COVID. Post training reinforcement was conducted to ensure that knowledge was translated into practice. These VHTs



were able to reach at least 36,666 people in a two-month period, creating awareness for improved referral from the community to health facilities. A majority of the VHTs acknowledge the gap of their absence in the response and pledged to support the MoH response interventions in the community level. Daniel (not real name) is a resident of Makindye division, in KCCA, which has registered COVID 19 cases. Like many residents of the division, Moses had never believed that COVID 19 was spreading in the communities.

*"Honestly, I had not believed that COVID 19 exists," he says adding that "in fact, if I had not been the Village Health Teams (VHTs) working in this division, I would have taken a long time to know all the facts about the disease. I am grateful for this training opportunity. In fact, until recently to Daniel and many of his VHTs, COVID 19 was nonexistent but just evil. Many believed the Ministry of Health (MoH) and partners "manufactured COVID 19 to make some money".*

One of the VHTs found herself on TV as representing the national cause of house to house sensitization on COVID 19.

With the surge in the COVID patient numbers, case management centers were established at Regional Referral Hospitals as a matter of policy. Key in case management is having appropriate triage systems. As part of enhancing the hospital environments to ably identify suspect cases, WALIMU in collaboration with the Health Infrastructure and Case Management Departments developed a prototype of an out patient triage for a regional referral hospital. Out patient triage centers were set up in all the 14 regional referral hospitals to ensure that the patient flow would protect the health worker while also providing an opportunity for screening for suspects and triaging cases for appropriate management. In Arua regional referral Hospital, given the infrastructural challenges, this provided an opportunity to color code patients for appropriate action as the hospital outpatient was now focusing on serious sickness only as it had decentralized other outpatient services. To functionalize the triage, the necessary tools and equipment for use by the health workers such as Infection Prevention and Control kits were also provided.

To ensure adequate human capital for case management, 411 health workers across the 14 Regional Referral Hospitals were trained in Triage, Emergency care and Management of Severe illness in the context of

COVID 19 and EVD. Focus was on management of Shock, Septic Shock, Oxygen administration and Altered consciousness. These were facilitated to run their own drills as part of the Continuing Medical Education.

- 951 VHTs trained
- 36,666 people in Kampala and Wakiso reached
- 755 Health workers trained

### **5.1.2 Driving the policy Agenda on Sepsis through generating evidence**

The African Research Collaboration on Sepsis (ARCS) consortium is dedicated to improving the outcomes of Sepsis patients across the African continent. The scarcity of data on Sepsis has made estimation of the Sepsis burden difficult. As a result, we continue to see poor outcomes from patients as a result of limited awareness and lack of prioritization of the condition.

The ARCS-Uganda cohort observational study commenced in 2020 in Uganda alongside Malawi and Gabon. The observational study aims at generating data in terms of the definition, epidemiology and outcomes of Sepsis. Novel therapies such as the use of Vitamin C and Thiamine in the management of Sepsis will also be tested. With the trial aiming at 600 patients, 539 participants have been enrolled which is about Some preliminary findings from the Study were presented at the World Sepsis Conference 2021.

Through ARCS, the Baseline African Sepsis Incidence Study (BASIS) was implemented in Uganda and 10 other countries in sub-Saharan Africa. Data collection in Uganda for this study was completed in November 2020. Results from this study will contribute significantly to accurate estimation of the sepsis burden in Uganda and Africa at large.

- 539 patients touched
- Six inhouse doctors trained through communities of practice



VHT dialogue at Nyakishenyi HCIII, Rukungiri District

## 5.2 Saving young lives presenting with Severe Infection

According to the Demographic and Health Survey (UDHS, 2018), 1 in 23 Ugandan children dies before reaching his or her first birthday, and 1 in 16 do not survive to his or her fifth birthday. This is largely attributed to socio-economic factors with the leading cause being poverty at the household and community level. For those where care is sought on falling sick, at the health facilities, the system factors at triage impede the ability to quickly detect and treat Severe Illness. Our interventions are twofold; At triage, we seek to reduce the time to treatment for the severely ill. On discharging a child previously admitted for Severe Illness, we ensure that they are followed up to ensure that they fully recover and do not go to die in the community.

### 5.2.1 Enabling children to receive the much needed lifesaving bundle

Preventable deaths in health facilities arising from Sepsis and Severe Illness while in hospital usually result from long waiting times to treatment. Our Smart Triage intervention seeks to strengthen the triage processes in overburdened health systems through reducing time to treatment. For a child with Sepsis, they should have received a “Sepsis Bundle” within one hour of arrival at a health facility. This bundle consists of

fluids, anti-biotics and oxygen as deemed necessary by the attending Clinicians. Our efforts in 2020 were geared towards developing and clinically validating a digital triage tool that will identify high risk children and reduce the wait time to receiving life-saving treatment. This would be complemented by an automated patient tracking system.

In collaboration with the University of British Columbia, we developed and tested the Pediatric Rapid Sepsis Trigger, a mobile based application to predict this. This was linked to a Smart Spot, a system that uses BLE and Wi-Fi technology to identify patient location and waiting times. This is then linked to a dashboard where the queue can be monitored and priority is given to the sickest patients. From the 1427 patients from whom baseline assessments were made,

- Only one out of 100 children received a sepsis bundle\* within 1 hour of arrival
- It takes 5.3 hours to receive that bundle
- Only one out of 100 children received antibiotics within 1 hour of arrival
- It takes 5.7 hours to receive an antibiotic

The Smart Spot has since been deployed in Jinja to aid in triage as part of a multi faceted Quality Improvement Initiative. Our effort in 2021 will target improvements in reversing these indicators.

### **5.2.2 Ensuring the survival of the vulnerable children leaving the hospital**

In Uganda, when children are hospitalized for a severe infection, about 5 per cent die and 95 per cent are discharged, presumably well. Alarming, 5 per cent of these children presumed well will die in the weeks after they return home. Health workers and parents are often unaware of this period of vulnerability and are poorly equipped to identify or handle this critical situation. An effective strategy is required to prevent these children from dying needlessly. We have previously developed a risk prediction model for post discharge mortality which has provided a basis for preliminary roll out of post discharge interventions premised on the principle that discharge planning starts by predicting the risk of mortality on admission. Our effort in 2020 has been on calibrating the model for under six children. The model has been calibrated basing on data of 2808 children who had a smart discharge across the Regional Referral Hospitals of Masaka, Mbarara and Jinja.



In a bid to generate additional evidence and better understand the pediatric discharge process in Uganda sufficient to guide policy, we evaluated the discharge pathway in 20 hospitals across Uganda and also embarked on a theorization of what an ideal discharge process should be. Our preliminary findings show that only one hospital had a discharge process, minimal socio-economic history taking, minimal education of caregivers on discharge care, haphazard discharge times among other issues. Full analysis is underway.

As part of closing of the barriers in post discharge care, we embarked on implementing a district model multi-faceted intervention in Gulu and Rukungiri Districts. This intervention sought to commence the discharge process at admission. At admission, a child is assessed for post discharge risk of mortality. High risk children are followed up upon discharge and linked to a VHT of their choice. Health workers and VHTs were trained on our “Smart Discharges Approach” to be able to roll out the interventions. 143 Health workers and 527 VHTs from 50 health facilities in Gulu and Rukungiri were trained. Upon completion of the training, our in-house SMS referral system to VHTs was implemented in 11 facilities. Patient outcomes are now being obtained for those who have completed the two months post-discharge period.

To further the post-training reinforcement messaging, VHT dialogues continue to be held from which experiences and challenges are shared and recommendations made. The key feedback reported from the VHTs was the quality of counselling they are now providing as they had not previously received any formal training on appropriate counselling techniques. The training also resonated with their personal experiences in the community as VHTs have reported that their self-esteem has improved since being woven into the health facility referral system.

*One VHT reported that during a follow-up visit, a mother told her that her first child died at home from severe anemia due to a lack of knowledge to identify the danger signs. The mother had appreciated that her local facility was now using the Smart Discharges program so that her second child is receiving compressive care that follows her child from the facility to home.*

We are now making revisions to our app to improve the community follow-up system based on VHTs and hospital Health Worker feedback. Efforts are now underway to incorporate the “Smart Discharges” into the Integrated Community Case Management component.

- 2 Districts
- 527 VHTs
- 50 Health workers
- 2832 children touched
- 50 health facilities

### **5.2.3 Enhancing the role of mothers in identifying severe illness in neonates**

Despite improved coverage of hospital-based maternal and neonatal care, the neonatal mortality rate in low- and middle- income countries (LMICs) remains high. The shortage of healthcare staff is an important contributor. Parents are vital partners in securing favorable neonatal outcomes. Involving parents in the hospital care of neonates may improve the quality of care provided to sick and small newborns. With funding from McGill University, WALIMU undertook a proof-of-concept study to test whether an adapted Family Integrated Care program is acceptable and feasible in a Ugandan neonatal unit. Specifically, the ongoing program trains mothers to assess their baby in three ways; 1) check for danger signs; 2) measure their baby’s weight; and 3) track their baby’s feeding progression during hospitalization. The results of this pilot study will inform future research and initiatives on enhancing maternal involvement in neonatal hospital care in Uganda.

We conducted pre-intervention interviews to obtain an understanding of the proposed program by the health workers and mothers. Eight healthcare workers (HCWs) from the Special Care Nursery (SCN) at Jinja Regional Referral Hospital participated in individual interviews. In addition, two group interviews, each with five mothers whose newborns were in the SCN, were conducted. The data was analyzed using content analysis. According to participants, mothers are currently the default primary caretakers in the SCN due to the high patient-to-HCW ratio. Yet, mothers often lack skills and knowledge needed to care for their hospitalized newborns because they do not receive systematic education or delineation of their roles. Maternal empowerment,

reduction of HCW workload and improved neonatal outcomes during hospitalization and after discharge were cited as potential benefits of implementing a structured format for maternal involvement in the SCN. However, participants raised concerns that some mothers may be incapable of learning the required skills and interpreting their findings. HCWs may not trust these mothers' measurements, and maternal stress may increase due to the increasing responsibilities.

We have completed our baseline data collection and are currently in the process of implementing the intervention phase of our project. Of the 53 babies' dyads enrolled in the baseline data collection (including deaths and runaways), 29 (55%) were male and the most common reason for admission to the SCN was asphyxia ( $n = 26$ , 49%). The mean gestational age at birth was 37 weeks with a mean birthweight of 3.0kg. In the 48 mothers who completed a Discharge Readiness Survey prior to their child's discharge from the hospital, 100% of mothers felt ready to take their child home. However, when asked to rank their knowledge about caring for their child at home with 0 representing "know nothing" and 10 representing "know all", the average response was 6.5. Additional analyses of the baseline data as well as the baseline data compared to the intervention phase has not yet been performed. While the preliminary findings provide optimistic results, we intend to further scale up the study to obtain more statistically significant data.



## 6.0 Corporate governance

2020 marked the first year of implementing our first strategic plan. The focus of the strategic plan is to invest in critical enablers for health workers to lead the health care transformation agenda.

### Board of Directors

Name	Field of Specialization	Institution of affiliation
Achilles Katamba Board Chair	Clinical Epidemiologist	Makerere University, Kampala
John Davis Lucian	Pulmonologist	Yale University, USA
Shevin T. Jacob	Infectious Diseases Physician	Liverpool School of Tropical Medicine, UK
Elijah Goldberg	Economist	Impact Matters, USA
Matthew O. Wiens	Epidemiologist	University of British Columbia, Canada
Nathan Kenya-Mugisha	Pediatrician	WALIMU
Adithya Cattamanchi	Pulmonologist	University of California, San Francisco





7.0

## Management Discussion and Analysis

We continue to align our human capital to match the emerging needs of the organization. Our headcount has almost doubled. This has come with the need to support our own through in house training and mentoring.

### 7.1 Capacity to serve

We implement our activities through a wide network. While we have a program team at the head office in Kampala, majority of our staff are deployed across the country mainly at the Regional Referral Hospitals where we are implementing initiatives to improve patient outcomes.

In line with our founders' vision of building and not replacing capacity, we also work through a network of clinicians countrywide, usually government health workers including nurses, doctors and consultants, to train and mentor colleagues. Since the role of ensuring treatment in this country is the mandate of the Ministry of Health, we maintain the relevant departments in the ministry such as the Clinical services Department in the driving seat of all our clinical interventions.



### 7.1.1 Human resources

S/N	Staff Name	Position	Academic Background
1	Nathan Kenya-Mugisha	Executive Director	MMed (Pediatrics), MPH
2	Savio Mwaka	Program Manager	MSc.(Quantitative Economics)
3	Betty Kuteesa Nalule	Finance Manager	PGD Management Science
4	Olive Kabajaasi	Program Manager	MA Sociology
5	Bernard Opar Toliva	Technical Advisor	MBChB, MCEB
6	Nsangi Damalie Kajumba	Project Coordinator	MPH
7	Sharon Nyesiga	Research Fellow	MMed Internal Medicine
8	Priscilla Haguma	Study Coordinator	MMed Internal Medicine
9	Alex Kityamuwesi	Study Coordinator	MBChB, MCEB
10	Mugabo Christopher	Study Medical Officer	MBChB
11	Omogor Paul	Study Medical Officer	MBChB
12	Rusoke Davis	Study Medical Officer	MBChB
13	Muwando Hida	Study Medical Officer	MBChB
14	Clare Komugisha	Senior Research Officer	RN, MPH

15	Charlene Kanyali	Operations Officer	BSc. Quantitative Economics
16	Catherine Kiggundu	Accountant	BBA
17	Carol Namiro	Accountant	BBA
18	Perusi Martha Nyakato	Administration Assistant	BA. Social Sciences
19	Twinamasiko Amon	Research Asistant	
20	Lamunu Maureen	Research Asistant	
21	Kunihira Lynn Tinka	Research Asistant	
21	Louis Okeny	Quality Improvement Officer	BPH
22	Ainembabazi Harriet	Implementation Nurse	
23	Nuwasasira Agaston	Implementation Nurse	
24	Naturinda Rabecca	Implementation Nurse	
25	Nakjafeero Joan	Implementation Nurse	
26	Kairangwa Racheal	Implementation Nurse	
27	Annet Maliza Kageyi	Implementation Nurse	
28	Kisaame Zorah Ruth	Implementation Nurse	
29	Kisaame Moshin Meshack	Research Nurse	
30	Kantono Maria	Research Nurse	
31	Busenze Bosco	Research Nurse	
32	Isiko Susan	Research Nurse	
33	Muteteri Judith	Research Nurse	
34	Nakasolo Moreen	Research Nurse	
35	Nakizza Josephine	Research Nurse	
36	Nabweteme Annette Mary	Research Nurse	
37	Nakasaga Babra	Study Time keeper	
38	Monero Angel	Study Time keeper	
39	Kusiima Solomon Amooti	Driver	
40	Kiyimba Titus Robert	Driver	
41	Were Badiru Mukose	Office Assistant	

### 7.1.2 Risks

The onset of COVID 19 came with an unexpected risk, with the national lock down and the Ministry of Health Preventive measures, several project deliverables could not be achieved as projected. A number of projects have had to seek no cost extensions. These however do not cover salaries for additional periods. We have had to reduce on staffing at some point to ensure project continuity.

## 7.2 Financial outlook

Our financial position has improved with grant income growing threefold, similar to the previous year. We have continued to better manage our administrative cost to below 18% in line with proper project management practice

Financial position			
Details	2020 (USD)	2019 (USD)	2018 (USD)
Assets			
Current Assets			
Receivables	32,683	2405.04	1,689
Cash and bank balances	329,105	125,340	92,176
	361,789	127,745	93,865
Current Liabilities			
Differed income	303,525	108,840	82,470
Creditors and accruals	21,576	18,589	7,599
Total current liabilities	325,101	127,429	90,069
<b>Net Assets</b>	<b>36,688</b>	<b>316</b>	<b>3,796</b>
Financed By:			
Accumulated Fund	36,688	316	3,796



Income and Expenditure			
Details	2020 (USD)	2019 (USD)	2018(USD)
Income			
Grant income	1,379,179	513,190	129,530
Other income	168.8	0.44	
Project expenses	(1,150,807)	(441,949)	(97,633)
Administrative expenses	(228,540)	(76,187)	(59,355)
<b>Deficit for the year</b>	<b>0</b>	<b>-4,946</b>	<b>-27,458</b>

Walimu has managed to improve steadily for the past 3 years with its grant income growth at a rate of 68.21% in year 2020, 25.38% in year 2019 and 6.41% in year 2018. With such income growth, Walimu is now able to fully fund its expenses with no deficit as reflected in the income and expenditure statement. The differed income which reflects funds advanced to run projects has also increased at a rate of 61.34% in year 2020 compared to 21.99% in year 2019 and 16.67% in year 2018. This reflects that Walimu has funds to run its project in its fore seeable future and is a 'going concern' organization. The 2020 accounts were audited by Cartwright CPA who gave an unqualified opinion.



Stakeholders meeting at the launch of the Smart Discharges at Kisiizi Hospital, Rukungiri

## 8.0 External engagement

Our approach to influencing policy into practice is largely through policy engagement. This involves disseminating findings from our implementation research activities in publications and conference abstracts. We also participate in several technical working groups with the Ministry of Health where we provide technical input.

### 8.1 Conference presentations, publications and news interface

#### Poster presentation

##### ***Exploring Healthcare Workers' and Mothers' Perspectives of Enhanced Maternal Participation in their Newborn's Hospital Care in Uganda***

Duby, Jessica<sup>1</sup>; Kabajaasi, Olive<sup>2</sup>; Tagoola, Abner<sup>3</sup>; Kenya-Mugisha, Nathan<sup>2</sup>; Wiens, Matthew O.<sup>4</sup>; Feeley, Nancy<sup>5</sup>

#### Poster Conference presentation

##### ***Parental Participation in the Care of Hospitalized Neonates in Low- and Middle-Income Countries: A Systematic Review***

Julie De Meulemeester\*, Anna Reiter\*, Matthew O. Wiens, Nathan Kenya-Mugisha, Abner Tagoola, Olive Kabajaasi, Jessica Duby,

## ***Fluid Resuscitation in Adults: Different Settings, Different Strategies?***

Shevin Jacob, African Research Collaboration on Sepsis, Uganda; World Sepsis Congress Presentation

### **8.2 Policy Engagements**

As part of our policy engagement agenda, we participate on a number of fora to push our approach on the policy agenda.

- i. Ministry of Health Non-Communicable Diseases Technical Working Group
- ii. Ministry of Health Reproductive, Maternal, Neonatal and Child Health Technical Working Group
- iii. National Task Force for Public Health Emergencies
- iv. Case Management sub-committee of the National Task Force
- v. Infection Prevention and Control Subcommittee of the National Task Force

### **8.3 Funders and partners**

- Liverpool School of Tropical Medicine
- Grand Challenges Canada (GCC)
- World Health Organisation
- University of British Columbia (UBC)
- McGill University
- University of California San Francisco (UCSF)
- Ministry of Health
- Africa Research Collaboration on Sepsis
- Infectious Diseases Institute
- Makerere University
- Novartis Social Business
- IMAi-IMCI Alliance
- Uganda Catholic Medical Bureau
- Uganda Protestant Medical Bureau
- I-streams Uganda
- Uganda Tuberculosis Implementation Research Consortium
- Centre for International Child Health – University of British Columbia

