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# HealthCLIR: UGANDA

## Health Business Climate Legal and Institutional Reform Assessment





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## AGENDA FOR ACTION

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# INTRODUCTION

This report examines the business-enabling environment for the private health sector in Uganda: the laws, institutions, and the social dynamics that impact the business of health. Through guided analysis, this report provides specific recommendations for donors, the government, and stakeholders to help reduce regulatory inefficiencies and improve investment into the private health sector in order to strengthen the quality, quantity, and dispersion of health services and goods throughout urban and rural Uganda.

## UGANDA'S PRIVATE HEALTH SECTOR—A WAKING GIANT

Uganda's current health system is not sustainable. External resources, primarily donor funding, account for approximately 31 percent of total expenditures on health in Uganda. Uganda self-finances only 10 percent of its HIV/AIDS care, relying upon donor organizations to pay the rest. Recently, media have reported that the Ministry of Health has been encouraged by certain donors to develop an exit strategy for funds provided through the U.S. President's Emergency Plan For AIDS Relief (PEPFAR), contemplating a Uganda health system facing drastic donor reduction. No explicit timeframe exists for a reduction in donor funding,[2] but the clarion call is clear: aid money can be unpredictable, restricted in use, and susceptible to political and economic influences. Uganda must determine how it will reorient its health system to sustainably improve the quality of, and access to, health services and goods to its people, rural and urban, rich and poor.

> We can't depend on foreigners to keep us alive. The government is not bothered to provide funds for the fight against the HIV/AIDS pandemic and this is dangerous.[1]
>
> *Mr. Livingstone Okello-Okello*
> *MP, Chwa County*

Donor assistance to the health system in Uganda has focused overwhelmingly on the public sector. This has tracked with the government's own statistics of the health system, which have traditionally overemphasized the percentage of services supplied through public facilities, while underreporting the scale of private sector involvement. This overlooks the major role played by the private sector in health services in Uganda. Initial surveys have been undertaken to try to capture the true impact of the private sector, specifically the private for-profit sector.[3] Further, of every four shillings spent on health care in Uganda, three shillings are private outlays, mostly in out-out-pocket payments direct to providers.[4] The message is clear—the private sector plays a substantial role in Uganda's health system, and therefore warrants special attention as donors and the government look at new approaches to rationalize the health system, and rethink the role of government in the health system.

Policymakers in Uganda have begun to waken to the great opportunities possible for the Ugandan health sector through private sector engagement and thoughtful regulatory reform. The second Health Sector Strategic Plan (HSSP II) emphasizes the importance of private sector engagement and will provide clarity of purpose to the Public Private Partnership for Health (PPPH) office within the Ministry of Health (MoH). However, many individuals within the health sector are concerned that the PPPH will merely serve as yet another arm of government seeking to exert control over the private health sector, with hands outstretched looking for yet another source for graft payments. Even the sincerest intentions for good, increased government

1 *Daily Monitor,* August 15, 2009
2 *Id.* Notably, an official communication from the U.S. mission to Uganda explicitly states a long-term commitment to health care financing.
3 Statistics on private for-profit health providers are difficult to obtain and are not accurately captured by the Ministry of Health. The estimates here come from the "Survey of Private Health Facilities in Uganda" produced by USAID under the PHRplus project in September 2005.
4 World Health Organization, *World Health Organization Statistical Information System (WHOSIS),* 2009.

collaboration with private sector health providers could lead to heavy-handed government policies—a control mechanism wielded by government ministers to use the private sector as an extension of government policy.

Key to PPPH success will be the MoH's capacity to provide a forum for private sector health providers so they can collaborate, identify best practices, and harness the creative engine of the private sector, rather than seeking to legislate outputs. Central to sustainable systemic reform will be the ability of all stakeholders to rationalize regulations governing the private health sector through informed collaboration, focus efforts away from direct delivery and toward formal quality-control interventions, and create market-based financing structures that empower consumers to incentivize efficient service providers by rewarding quality services.

Building upon the *2008 BizCLIR Uganda Agenda for Action* examining the business-enabling environment and its impact on private sector development broadly within Uganda, this report delves into specific issues affecting the performance of the private health sector.[5] Based upon an analytical framework described in detail below, this report looks at the regulatory environment impacting the private health sector, identifies discrete interventions that could support the continued development of the private health sector in Uganda, and provides key steps to put the recommendations into operation.

As donors over time rethink funding priorities, an engaged private sector will be imperative for sustainable improvements to health outcomes. However, lasting system improvement must be owned and driven by informed local stakeholders, as their future rests in their own hands.

## THE HealthCLIR DIAGNOSTIC PROCESS

From July 6–17, 2009, a six-member team of international consultants, facilitated by a member of the Ugandan health community, conducted informational interviews with over 120 local stakeholders in the private health system. Stakeholders interviewed included public and private health service providers, governmental and quasi-governmental facility and health professional regulators, bankers, pharmacists and medical goods importers and producers, educators, legal professionals, health policy professionals, consumers groups, and many others. The assessment was centered primarily in the greater Kampala and Entebbe region, although the diagnostic included regional trips to Masaka, Jinja, and Gulu to gain perspective outside of the capital region.

The in-country diagnostic activity culminated in a stakeholder roundtable activity, attended by approximately 90 members of the public and private health providers, financial service providers, doctors, government officials, and other stakeholders. The stakeholder roundtable was organized to present initial, generalized findings of the assessment team and served as an opportunity to engage the participants for their own observations on the team's thematic observations to promote collaboration via facilitated break-out groups.[6] The outputs from this stakeholder roundtable were used to provide added depth and local perspective to this report.

This HealthCLIR diagnostic focuses its findings and recommendations on those elements of the business enabling environment and health system that uniquely impact the private health sector. Leveraging the previous Uganda BizCLIR diagnostic, this assessment looks at five subject matter areas impacting the private health sector: Delivering Goods (supply chain for pharmaceuticals, medical supplies, and devices); Developing Human Capacity; Accessing Finance; Providing and Maintaining Facilities, and Governing the System.

Each chapter of this report has the same organization throughout, broken down by the same four lenses through which this diagnostic peers into the regulatory environment for the private sector. Every section also has included targeted recommendations at the end of each chapter.

5 For a full understanding of the business enabling environment as it impacts the private sector generally in Uganda, the BizCLIR Uganda Agenda for Action can be found at www.bizclir.com, along with diagnostic reports from 40 countries that have already conducted BizCLIR assessments.

6 The break-out groups were engineered to ensure that each group had at least one participant from the government, one participant representing the private-for-profit sector, one participant from the private-not-for-profit sector to encourage collaboration in establishing the group's observations and recommendations for health system reform in Uganda.

### LEGAL FRAMEWORK

Each chapter commences with a review of the legal framework, the written laws, regulations, policies, and binding documents that establish the organization for that particular component of the health system. Key to this analysis is both a qualitative review of the laws themselves as compared to international best practices, as well as questions involving the ability of parties to access those laws. Important in the review is understanding how well the laws achieve their proposed objectives, and the extent to which the laws are effective at creating a framework that is workable for all stakeholders as the framework is applied.

### IMPLEMENTING INSTITUTIONS

The chapters then look to the institutions and stakeholders that have primary responsibility in implementing their respective parts of the health system. Implementing institutions can be governmental, quasi-governmental, or private sector entities, self-regulating professionals, facilities, educational standards, or other components of the health system. Key areas of inquiry within this part of the chapter look at the quality, capability, and resources of each implementing institution.

### SUPPORTING INSTITUTIONS

Implementing institutions do not govern in a vacuum; rather, they rely upon many other stakeholders in the performance of their duties. The chapters look at those stakeholders that serve as critical components, without which the implementing institution(s) could not perform their functions. Typical examples of supporting institutions in some sections could include advocacy organizations, customs clearance firms, lorry services, banks, attorneys, among others.

### SOCIAL DYNAMICS

Lastly, the sections look at the social fabric within which the system operates. This section looks at social norms, customs, especially targeting those issues that directly or indirectly impact the performance of the system. Issues such as treatment of minority populations, gender, accountability and public perception of institutions, and access to information can significantly impact the performance of the enabling environment for health care.

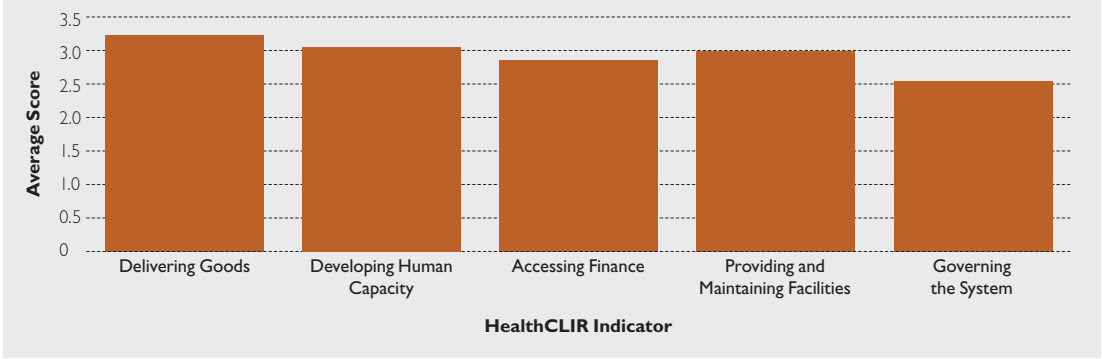
### RECOMMENDATIONS

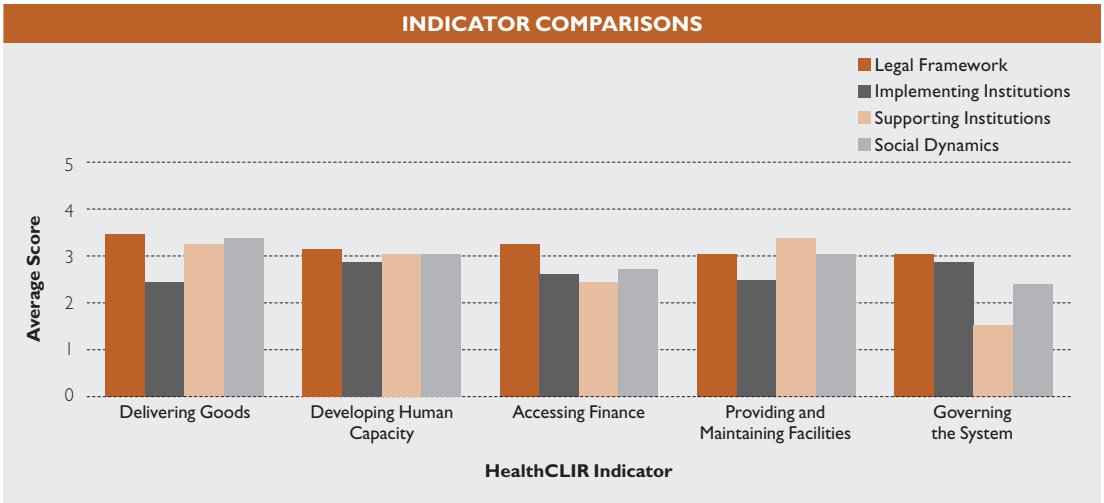
Based on key observations of the team, the Appendix of the report contains recommendations for reforms, ranging from general system-wide recommendations to detailed suggestions for targeted reforms. Based upon specific requests, the recommendations provided by the team are limited in number to those perceived by the team to yield the greatest impact. The recommendations are presented in a manner that identifies clear issues, suggests potential action items to operationalize the recommendation, and provide expected outcomes.

## SUMMARY OF DIAGNOSTIC FINDINGS

The findings from this diagnostic point to a system that appears strong on paper but is lacking in implementation. As the figure below shows, the

**INDICATOR SCORE COMPARISONS**






diagnostic pointed to the greatest needs for regulatory reform exists in the areas of Governing the System and Accessing Finance, while the regulatory framework for Delivering Goods throughout Uganda was relatively the strongest.

Generally, the Legal Framework for each indicator set, i.e., the official laws, regulations and policies as written, was relatively strong in Uganda. The weakest areas of each section generally were the institutions charged with implementing or enforcing the Legal Framework.

## CROSSCUTTING THEMES

Although this report focuses on the application of a standardized analytical framework through five discrete sets of indicators for effective private and public sector participation in the health system, certain themes were so prevalent across multiple sections that they warrant special consideration.

### CONSUMER PROTECTION AND QUALITY OF HEALTH CARE

The importance of consumer protection and quality of care is a theme that directly or indirectly cuts across every section of this report. Indeed, in Uganda where successful attainment of the Millennium Development Goals related to child mortality and maternal health are deemed by the United Nations Development Program to be "unlikely" by 2015, quality care and consumer protection are especially important. With increasing demand for health services—due in part to a high population growth rate and the prevalence of HIV/AIDS, tuberculosis, malaria, and other communicable diseases—Ugandan health consumers are growing in number and are major stakeholders in the health system.

Consumers of health care in Uganda are generally disempowered and unaware of where to turn for legal protection in the instance of medical malpractice or mistreatment. Though there are some organizations that advocate on behalf of patients, such as the Uganda National Health Users'/Consumers' Organization (UNHCO), they are limited in their ability to enforce standards and ensure quality. The UNHCO's recent success in securing the Ministry of Health's approval of the Patients' Charter, which calls for basic health rights such as the right to treatment, the right to non-discrimination and the right to redress, is a positive sign that consumer protection is on the government's agenda. A truly collaborative effort, the Patients' Charter was developed by working groups consisting of members from government departments, such as the Ministry of Health's quality assurance department, as well as various civil society organizations. However, UNHCO recognizes that the next step—*enforcing* the charter—requires strong government will, donor collaboration, and coordination among civil society groups.

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Consumer confidence in the quality of health services varies in Uganda, depending on the sector of health care. The health consumers interviewed for this study uniformly expressed that public health facilities lack adequate supplies and tend to have poorly managed staff with low morale. While staff morale seems to be greater and services are provided more efficiently in the private sector, consumers are burdened by the high cost of accessing private health care. A majority of health insurance in Uganda is provided privately through formal employers. Community health insurance schemes are only available in some of the western regions, with none available in the Kampala area. Therefore, for those who are unemployed or do not receive insurance through their employer, the cost of health care is an inhibiting factor to accessing quality care. Health consumers of both public as well as private facilities expressed having to pay additional fees for service. Furthermore, gender, age, and HIV/AIDS status were most often cited as sources of discrimination, either in the form of being turned away from a medical facility or receiving delayed treatment.

While consumers of pharmaceuticals face legitimate concerns about the quality of drugs, the quality of drugs in Uganda has improved somewhat over the past five to six years, due in part to the efforts of the National Drug Authority, as well as drug wholesalers and importers. Still, a shortage of drugs in public facilities, the high cost of drugs, and a fear of counterfeits continue to pose problems for consumers.

## DONOR DISTORTION

Donors and international non-governmental organizations (NGOs) have had a significant positive impact on development in Uganda. However, flush with cash in comparison to local organizations and eager to see their projects succeed, many donors offer salaries and benefits that attract the most talented workers from the country's employment pool. In the health sector, this often means that health workers move away from clinical professions and into administrative and management positions for internationally funded projects. In some instances, individuals are hired below their credentials. For example, a medical doctor may be hired for a position that does not require a clinical background.

The phenomenon of internal "brain drain" of the most talented employees away from clinical medical positions and toward donors and NGOs can be particularly detrimental in a country, such as Uganda, that is already facing a health worker shortage. Some donors recognize that salary schedules are not based on a rigorous analysis of the local labor market. In many cases, remuneration offered by donors and NGOs dwarf that paid in the local health sector, in both private and public institutions. Whereas an entry-level doctor in Uganda might make 600,000 shillings ($287) per month working in a public facility, the same person may find a job with a donor or an international NGO that pays five times that amount or more.

While there is an argument to be made for letting the free market operate naturally, because donors are disproportionately influential, they cannot be considered as "indigenous" actors in the local economy. Although their presence is temporary, they drive up costs and cause long-term distortion in the economy when their funding leaves the country. By offering substantially higher salaries for individuals with

specialized medical training than what local labor markets can otherwise bear, donors distort the health labor market, making the business of delivering health services more difficult for local health employers who cannot afford to compete with donor salaries for talented staff. Similarly, when donors supplement the salaries of selected individuals within a public facility or private not-for-profit (PNFP), this compromises the organizational culture and further erodes staff morale.

This raises the question of whether donors have a responsibility to actively manage their impact on the local economy in an effort to minimize any distortion and ensure that the country's most talented human resources are best positioned to help improve Uganda's health outcomes.

## REGULATIONS AND STANDARDS

Interviewees across all sections agree that there is a lack of clarity surrounding the standards and regulations that govern the health system in Uganda. The standards and regulations are described as being "out of touch," inconsistently enforced, and unclear. The professional councils that register and license medical professionals, such as the Uganda Medical and Dental Practitioner's Council, are grossly under-resourced, impairing their ability to enforce standards and assure quality of health workers and facilities. For example, it is difficult for councils to revoke the licenses of those practicing with expired licenses because of the lack of financial and human resources required to accomplish this task. While the National Supervision Guidelines for Health Services does exist, health facility workers expressed frustration that meeting the guidelines does not necessarily guarantee accreditation. Furthermore, health inspections do not occur regularly, often taking place once every several years.

Along with the councils, district health officers (DHOs) also conduct inspections of health facilities. However, because private for-private (for-profit) (PFP) providers do not receive financial support from the government, there is confusion as to whether they must comply with the standards enforced by DHOs. Due in part to unclear guidelines for the regulation of the PFP sector, many PFP practitioners and facilities receive minimal regulation and supervision. In addition, there is no system for regulating traditional and complementary medicine providers. Traditional healers are commonly used, as an estimated 60 percent of Ugandans visit traditional healers before turning to either a public or private health care provider.

Within the drug supply chain system, there are complaints that the National Drug Authority regulates retail pharmacies unevenly and inconsistently by restricting licenses to pharmacies.

## INFORMATION, TRANSPARENCY, AND ACCOUNTABILITY

Free information flow between the public and private sectors, as well as from the government to the public, ensures accountability and transparency in the health system. A major barrier to this in Uganda is the fact that laws are not easily accessible to either the legal community or the public. The Law Development Centre is mandated to produce copies of all laws and policies; however, due to shortages of resources and equipment, not all of the laws are available. Furthermore, the most recent updates of many laws and policies have not been finalized, leaving draft forms of the documents to stand in as laws.

Due to the long-standing relationship between the PNFP sector and the government, PNFP health providers actively seek the opportunity to share information and data with partners, including the government, and see this as a means to advance their mission of providing health services. PNFP providers typically receive financial support from local governments, through primary health care (PHC) grants, disbursed at the direction of the district health officer, which incentivizes PNFP data production. However, this is not the case within the PFP sector.


# DELIVERING GOODS

Uganda's medical supply sector is undersized, and beset by weak regulatory implementation, distribution difficulties, and ineffective institutions. Uganda is a landlocked country with very low per capita income, problems with corruption, underdeveloped infrastructure, and internal and external brain drain.

There are a number of issues that are unusual or distinctive to Uganda. For example, the medical supply sector shows a very low level of concentration at all levels of the supply chain. There are several local manufacturers and more than 30 different importers. Government distribution is concentrated in a single entity, the National Medical Stores, but private and NGO sector distribution is widely dispersed. The retail sector is the most fragmented of all: over 80 percent of all drugstores in Uganda are sole proprietorships, and the largest chain in the country has only nine stores. Most importers are also wholesalers, and vice versa, but otherwise there is no vertical integration. Overall the sector is extremely fragmented.

Uganda has a small drug manufacturing sector consisting of six or eight local companies. The country has never had a chemical industry, so it has a very limited capacity to produce active pharmaceutical ingredients (APIs). The country is heavily reliant upon imports of both raw materials and finished drugs. Most raw APIs and other raw materials—pharmaceutical sugars and starch, and such—are imported.

The locally produced pharmaceuticals are mostly basic drugs such as aspirin, paracetamol, amoxicillin, and the like, although one large local producer is able to manufacture AZTs and antimalarials. Ugandan drug manufacturers do not produce anything for export.[7] The balance of trade in pharmaceuticals is strongly negative and has always been so. The major source of imports is India, followed by Europe (particularly Britain and Germany), South Africa, Malaysia, and China. The total value of drug imports (not counting donations) was approximately $200 million in 2008, or about $7 per Ugandan. Roughly 20 percent of this represents purchases by the private sector.

Uganda has almost no penetration by multinationals. Only wealthy Ugandans can afford branded drugs, so they account for less than one percent of private sector drug sales by volume and about two percent by price. The overwhelming majority of the country uses generic drugs. Uganda's pharmaceutical supply chains are distorted by its inland location and weak infrastructure, heavy donor involvement, and fragmentation of the market, especially at the wholesale and retail levels. Unlike many developing countries, Uganda has no large distributors; instead, the middle of the supply chain is a disjointed quilt of donors, public sector actors, the Joint Medical Stores, and about 30 different wholesalers. On one hand, this means that no single entity (except perhaps the National Medical Stores) has significant market power. On the other, it means that the supply chain is fragmented and severely undercapitalized.

Stock-outs are common across the system, but especially in the public sector. In the last year, there have been country-wide stock-outs of such common items as medical gloves and paracetamol, and regional stock-outs ranging from ether to insulin. A 2004 survey showed that almost half the medicines on Uganda's Essential Medicines List were not available in the pharmacies of the largest (referral) hospitals. The situation has improved slightly since then, but spot checks consistently show that stock-outs are common throughout the system. Stock-

7 This may change soon; see the discussion of Quality Chemicals, below.

**BANGALORE, KAMPALA, NEW YORK: INFRASTRUCTURE AND SHIPPING COSTS**

The vast majority of Uganda's drugs and medical supplies arrive overland from Mombasa. Most of this comes by road, as the single rail line is barely operating.

To ship a typical 40-foot freight container of drugs and medical supplies from Bangalore to Mombasa—about 3,000 miles—costs $800–$1,200, not including insurance, and takes about seven to nine days. To move the same container overland the 600 miles from Mombasa to Kampala costs U$3,000–$3,600 and takes between six days and three weeks, with 10–14 days considered average. By way of comparison, shipping the same container from Bangalore to New York would take about 25–30 days and would cost about $5,000.

Importers agree that while costs are high, the real concern is uncertainty. Delays, especially at the border, can drag on for days, endangering cold chains and disrupting supply schedules. The long lead times—three weeks or so from South Asia, and longer from Europe—contribute to supply fluctuations and stock-outs; if the country as a whole runs short on a drug, it will take at least that long to restock.

outs disproportionately affect the poorest Ugandans; patients are frequently forced to go without medicines needed to treat serious conditions that are otherwise treatable or preventable. Stock-outs are more than an inconvenience; they can leave patients facing serious illness or death.

Stock-outs are just part of a more general problem, which is that Uganda's supply chains are notorious for sudden fluctuations in both price and availability. Common products may suddenly disappear off the shelves regionally or nationwide. Prices can soar or crash on very short notice. Public, private, and NGO actors all agree that the unpredictability is a major constraint on providing high quality health care.

Prices generally are high, although this varies greatly from drug to drug and from place to place. Some treatments are subsidized, either by the government or by donors, and so are inexpensive or free. Other drugs are cheap because the fragmented system allows a high level of competition for common molecules. However, drugs generally tend to be expensive because of high transport and distribution costs and the lack of economies of scale. Also, many drugs are local monopolies, available only from a single importer or wholesaler. These tend to be as expensive as the market will bear.

Medical equipment is distributed very unevenly across the country. For example, several public referral hospitals lack CD4 machines, even though these are deemed essential equipment in a country with a major AIDS problem.[8] For another example, some laboratories lack microscopes, even after years of donor attempts to bring basic equipment wherever it is needed.

Maintenance of equipment, especially complex lab equipment, is a problem that has somewhat improved in recent years, but equipment failure may take weeks or months to repair. Uganda simply does not have enough trained technical personnel to maintain its lab equipment. Depending on how complex the machine is, repairs may require a technician to be flown in from Nairobi or South Africa.

IT penetration is very uneven. Many hospitals, clinics and firms in Kampala have modern hardware, useful software, and internet access. However, outside Kampala, even large hospitals may have only limited access to modern IT, and only a handful of staff are likely to be trained in its use. As a result, inventory management is weak, and supply chains are not managed efficiently. Poor access to IT (and poor use of the IT that exists) is a significant factor in stockouts.

Finally, much of the country's population has little or no access to prescription drugs. According

8 There are over 100 CD4 machines in Uganda, only 11 of which are in the public sector. These are supposed to be used for 150,000 people on subsidized ARV treatment, each of whom is supposed to be tested twice per year. This works out to about 27,000 runs per public sector machine per year. Unsurprisingly, breakdowns are an issue. To make matters worse, CD4 reagents need a cold chain; thus, it is not unusual to have a machine ready to go but out of reagents. Meanwhile many HIV-positive Ugandans are forced to wait for tests, pay for private sector tests, try to get help from NGOs, or simply forgo the tests altogether.

to the UNDP,[9] approximately 40 percent of Uganda's population lives on $2 per day or less. These people simply cannot afford unsubsidized pharmaceuticals. The World Health Organization (WHO) classifies Uganda as a country where a significant minority of the population entirely lacks access to drugs or primary health care.

## LEGAL FRAMEWORK

On paper, Uganda has a very solid legal framework for the delivery of medical goods. Most of Uganda's laws and regulations are based on British models, and for the most part they are clearly drafted and consistent with international best practices. By and large, the laws are not the problem.

The Ministry of Health (MoH) is given overall responsibility for delivering health care, while the National Drug Administration (NDA) is charged with regulating the import, production, distribution, and sale of drugs and medicines. The laws and regulations give these agencies fairly clear responsibilities and powers, and establish a framework of penalties for violations. The result, on paper, is a mixture of public and market responsibility for the delivery of medical supplies and pharmaceuticals, similar to the structures found in many advanced countries.

In practice, the situation is more complex. Resources are limited, so the laws are not always implemented or enforced. Some agencies have adopted particular interpretations of the laws and regulations; these tend to go unchallenged, even when they are obviously a long stretch from the letter of the law.

Ugandan law requires public hospitals and clinics to use generics. Branded drugs are not allowed unless they are completely paid for by a donor or other outside source; or a doctor can demonstrate a compelling need for that particular molecule. This rarely happens Multinationals have so far shown little interest in trying to market branded drugs in Uganda.

Uganda is a member of the WTO and of the East African Community (EAC). It is anticipated that regional agreements will begin to affect the drug market soon (for instance, by allowing regional approvals for new drugs, or at least standardized applications) but so far, regional harmonization efforts have not begun. There is very little intraregional trade in drugs or medical supplies within the EAC, although South Sudan tends to source its drugs from Uganda (see below) and Quality Chemicals hopes to market and export throughout the EAC region and beyond (see below).

## IMPLEMENTING INSTITUTIONS

### MINISTRY OF HEALTH (MoH)

Uganda's Ministry of Health has primary authority for regulating the health sector. The ministry also oversees all public sector health care providers, from referral hospitals to Level 1 clinics.

The Ministry of Health's administration is geographically decentralized among the country's districts.[10] Procurement of drugs and medical supplies is developed at the sub-district level but coordinated at the district level; each district places its own, collective orders for its hospitals and clinics with the National Medical Stores. To complicate matters somewhat, large hospitals may also conduct their own, supplemental procurements.

The Ministry of Health is responsible for the disposal of expired drugs, but there is a general perception that this is not done well. (See Reverse Logistics, below.)

**KEY IMPLEMENTING INSTITUTIONS**

- Ministry of Health (MoH)
- National Drug Administration (NDA)
- National Medical Stores (NMS)
- Joint Medical Stores (JMS)
- Drug importers and manufacturers
- Local manufacturers

9 A detailed discussion of poverty in Uganda is beyond the scope of this chapter. However, several useful recent papers can be found at http://www.chronicpoverty.org/page/uganda-key-publications.

10 The exact number of districts keeps changing, which is itself a problem: every time a new district is created, it needs its own procurement and its own sub-district distribution system.

### PROCUREMENT OF MEDICAL GOODS: THE PPDA

Uganda's Public Procurement and Disposal of Public Assets Act, 2003 (PPDA) is widely perceived to ill-fit the needs of the health sector. The act is seen as a "one size fits all" law that does not take into account the special needs and problems of the health sector. According to the NMS, procurement policy is one cause of stock-outs, and several public sector interviewees agreed.

The PPDA allows free procurement of small purchases (up to 2 million shillings), but purchases of 2 to 50 million must be evaluated, which can take months. Larger purchases must be made through a formal competitive bid. Bid awards are dominated by price, as opposed to the best value for the government. Considerations such as reliability and swiftness of delivery, very important in medical supply chains, are given little weight. Challenges to awards are common, and can delay purchases by months. PPDA procurements are thus slower and more expensive.

The bid process itself is inefficient and requires bidders to submit the same information multiple times. There is no centralized accreditation for suppliers, so each hospital, clinic, and district may demand a complete set of documents before allowing a bid. Although, in theory, bids cannot take place without a certification that funds are available, in practice, funds are often diverted or delayed.

The MoH supports a number of semi-autonomous advisory bodies, at least one of which (the National Advisory Council for Medical Equipment) has some influence on supply chain issues. The Advisory Council publishes guidelines for hospitals and clinics as to what equipment they should have—i.e., what is appropriate for a level 2, level 3, referral hospital, etc. It is active but meets irregularly.

## NATIONAL DRUG ADMINISTRATION (NDA)

The NDA is responsible for licensing and regulating the delivery of pharmaceuticals in Uganda. The NDA is responsible for testing all drugs—including bioavailability and bioequivalence testing—and also, in theory, for pharmacovigilance, including post-sale surveillance and monitoring of adverse reactions.[11] The NDA has about 120 employees; it is based in Kampala, but has seven regional offices.

Most actors in the sector perceive the NDA to be well intentioned but badly underfunded and understaffed. The NDA lacks, among other things, dedicated IT personnel and a library, though one has been in the planning stage for years. The NDA does receive significant donor aid, especially from the WHO,[12] but it still suffers from a painful lack of resources.

The NDA keeps a registry of acceptable sources for all drugs in Uganda's pharmacopeia. It charges factories for inspections and for keeping their products in the registry. This charge pays for, among other things, an inspection of the facility once every three years. The NDA staff members make regular trips abroad, especially to Europe and South Asia, to inspect and approve factories there. Interestingly, the NDA does not do source approval for lab reagents. Bad reagents are said to be an issue, but the NDA lacks the resources to deal with this.

There are many complaints against the NDA, although in many cases it is difficult to assess their validity.[13] However, it is clear that there are some problems. Introducing a new drug is extremely complicated, and can take several years. The NDA believes it has the power and duty to regulate the location of new pharmacies. No specific laws or regulations were identified that bestow this degree of regulatory authority on the NDA, and, in any event, is a waste of limited resources. The NDA charges donors a "verification fee" to approve drug donations; this used to be 0.8 percent of the value of the donation, but was recently increased to 2 percent.

The NDA openly admits that the fee increase is not based upon the actual cost of "verification," but rather to increase the income the

11 NDA has a randomized testing regime, but it does not appear to be applied rigorously. In fact, it is not clear whether NDA is conducting regular randomized testing at all.

12 WHO did an assessment of the NDA 2009.Despite best efforts, the team was unable to obtain a copy of this report.

13 For instance, drug manufacturers complain that the NDA is slow and expensive, hospital officials say it sometimes makes arbitrary decisions, while retailers protest its policy of controlling where new retail pharmacies can be opened.

NDA derives from the fees. The NDA is almost entirely self-funded.[14] The government pays less than 10 percent of the NDA's budget; it must find the rest on its own, by fees, fines, and charges. The underfunding of the NDA creates perverse incentives to boost agency income through any means necessary. The NDA's underfunding also limits its enforcement capabilities, and will continue to do so for the foreseeable future.

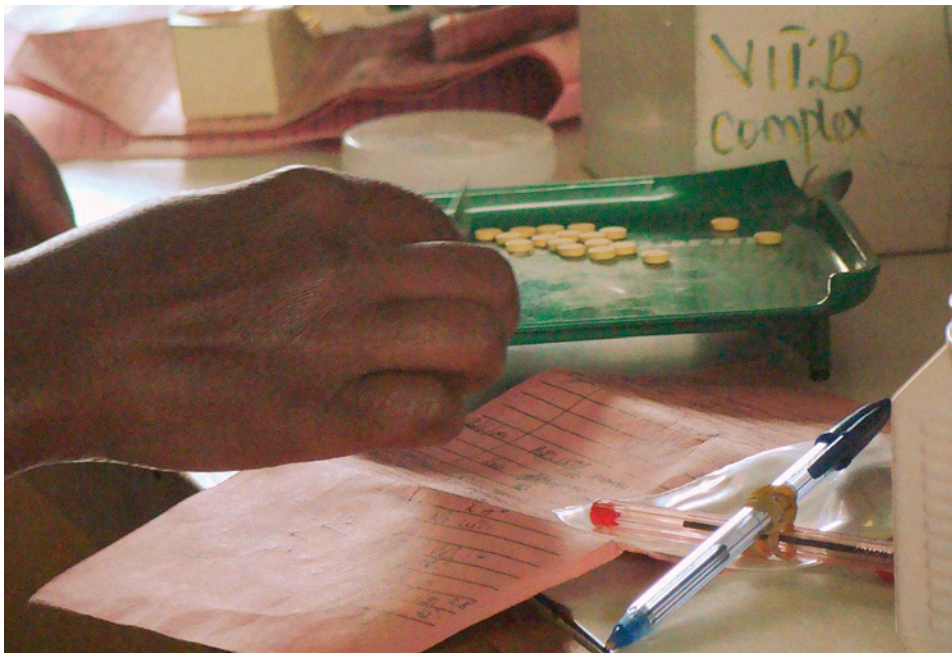
Despite the NDA's limited resources, it is—by regional standards—relatively successful. It is not perceived as particularly corrupt. There is general agreement that the NDA managers take their jobs seriously. All interviewees agreed that the problem of counterfeit drugs has greatly improved in the last five or six years, and that this is at least in part because of a concerted effort by the NDA.[15]

## NATIONAL MEDICAL STORES (NMS)

NMS is a state-owned enterprise tasked with the procurement, storage, and distribution of drugs and medical supplies for all public hospitals and clinics.[16] The NMS deals in a wide range of products, including condoms, syringes, lab reagents, and sundries, but most of its stock consists of drugs. It is not formally a branch of the government, but is 100 percent state owned and is overseen by the Ministry of Health. (MoH appoints the NMS director for a four-year renewable term, but cannot remove him.) It is based in Entebbe, where it has a large warehouse.[17]

The NMS began as a "push" system, under which the government would buy medicines and distribute "kits"—complete medical packages—to local districts. Over time it has evolved into a "pull" system, with procurement based on what public health facilities need. Money for procurement was originally kept at the NMS, but with decentralization, control of these funds was moved to the districts.

In the last few years, the NMS suffered from being perceived as "run down," unreliable, inconsistent, and very slow, as orders got




delayed or even lost. Inadequate funding meant that even basic drugs were often out of stock, and yet poor warehousing procedures and an unenforced "first-in first-out" policy meant that some medicines would merely expire on the NMS' shelves. Although the government, at one point, considered disposing of the NMS, the government now plans merely to reform NMS. A new management team was put in place in April 2008 with a broad mandate for reform. The government is also considering "recentralization" of procurement—returning the mandate for some or all public drug procurement back to the NMS, away from the districts—though this process has not yet commenced.

Most interviewees agreed that there has been a change in the NMS. For example, the new management has started publishing drug distribution schedules.[18] Delivery has also improved dramatically, but there little consensus on the quality of the NMS. While some interviewed for this assessment believe that the NMS has reached a level of basic competence, others say they would not trust it and would still prefer to procure from the private sector or JMS.

NMS does some of its own importing, but also procures some drugs locally—both from local

14 A detailed breakdown of NDA's funding sources is not readily available. All interviewees agreed that NDA is largely self-funded from fees, with only a small percentage of support coming out of the government's budget. However, a breakdown of just how much funding is coming from which fees would be very useful for further analysis.

15 "Improved" is a relative term. There is general agreement that counterfeit drugs are still a serious problem, but that things are much better than they used to be.

16 The NMS does not supply the private sector. It does not have a mandate to do so, and in any event it lacks the capacity.

17 The NMS is located in Entebbe for historical reasons. The current management would like to move it to a more central location, as Entebbe is not ideal from any point of view. (It is close to the airport, but very few drugs come in by air.) However, this would require a significant expenditure of funds, including the construction of a new warehouse.

18 This is partly to restore public confidence, and partly as a prophylactic against certain sorts of corruption; if the local newspaper posts that a specific clinic has just received 20,000 units of amoxicillin, it will be hard for the clinic pharmacy to claim that it is out of that drug.

### THE LAST MILE PROBLEM

Drugs and medical supplies for the public sector are distributed from the NMS to the district level. From there, it is the district's responsibility to distribute these goods to the sub-districts. In practice, this is often a major challenge; medical goods make their way to the "last mile" to the consumer, but fall through the cracks in the delivery system.

Districts generally have just one or two vehicles to move drugs and supplies. Vehicles are often old and difficult to maintain. Local roads can be very bad. Warehousing and inventory at the district level varies wildly in quality and efficiency; some districts have excellent regional warehouses with trained, honest staff, internet accessibility, and software, while others have none of these. Drugs may wait at the district level for days or weeks before being distributed. Relatively minor problems such as an engine breakdown can increase these delays dramatically. Smaller and rural clinics get drug deliveries only once per quarter, or even less often. Stock-outs are common, expiration is a major issue, and the delivered drugs and supplies may not meet current needs.

Personnel issues are also a problem. Each sub-district is supposed to have an accounting officer, who is responsible for keeping track of the sub-district's needs and summarizing them into orders for the NMS. However, in many cases this position is not filled; it may be done on the side by another health officer or by some person who is not trained or qualified. Sub-districts are particularly afflicted by the internal brain drain, as competent staff members are likely to leak away to NGOs or to Kampala.

Under these circumstances, the already weak system of inventory control is likely to break down entirely, making it impossible to keep track of drugs and supplies as they move through the system.

manufacturers and from Williams Street. Local manufacturers are at a disadvantage, however, because the law does not allow the NMS to consider delivery time when making a procurement award, which is its major advantage over South Asia. The procurement law emphasizes cost, rather than total value, and local manufacturers are not particularly competitive on this point. The large exception to this procurement law limitation is Quality Chemicals. Because of the government's seven-year agreement, Quality Chemicals has a monopoly contract to furnish artemisinin combination therapies and antiretroviral therapy drugs purchased with government funds.[19]

The NMS has had cash flow problems in the past, and to some extent this is still true. The Ministry of Health is supposed to pay the NMS for its sales to public hospitals and clinics, but payment is often delayed for months. The NMS has several times had to take out short-term loans from a local bank to buy drugs and supplies.

If the NMS is unable to provide a particular drug or supply, it is supposed to give a "certificate of unavailability" instead. This will allow the health care facility to obtain the drugs elsewhere. In theory, no government clinic or hospital can get drugs from outside NMS without a certificate of unavailability. In practice, the line is often blurred; clinics are often eager to use the JMS or a private supplier instead of the NMS.[20]

## JOINT MEDICAL STORES (JMS)

The JMS is a non-profit organization founded by two religiously affiliated private-not-for-profit (PNFP) groups in 1979 to handle medical relief.[21] Over the years, it has evolved into a major wholesaler of drugs and medical goods. The JMS has 71 employees and is entirely self-financing; it does not need to turn a profit, but must generate regular cash surpluses[22] for reinvestment, since it does not have access to formal credit.[23] Its annual turnover is about $20 million.

The JMS services the public, private for-profit, and private not-for-profit sectors. Like the NMS, the JMS has a single facility, located in downtown Kampala. The JMS does some of its own importing, and also sources goods by purchase from local manufacturers and Williams Street.

19 The NMS can purchase drugs from sources other than Quality Chemical when using non-government money, i.e., from PEPFAR or the Global Fund.

20 For instance, an e-mail, or even a phone call, saying a drug is not available at the moment may be taken as equivalent to a certificate of unavailability.

21 To simplify, before 1979 both the Catholic and Protestant churches had medical relief organizations. They decided that duplication was wasteful and pooled their efforts into the JMS. The JMS is still jointly owned by the churches; it is run by a board of directors, of which four are Catholic, four are Protestant, and three are independent experts.

22 As a non-profit organization owned by churches, JMS prefers not to use the term "profit."

23 The JMS has never taken a bank loan. However, the JMS wants to expand dramatically—upgrading the Kampala facility, building up inventory, and possibly opening a satellite facility up country. This will require financing, from a bank or elsewhere. For more on limitations to accessing finance, see the Accessing Finance chapter.

### COLD CHAINS

Uganda has an excellent system of vaccine distribution, with cold chains throughout the entire country. Unfortunately, this system does not go beyond vaccines, and cold chains for other drugs are much less reliable. Many rural areas of Uganda have limited access to electrical power, and must have generators to run their refrigerators. Parts, maintenance, and fuel are expensive. Cold chain breaks are much rarer than in the past, but they do occur; one recent break led to insulin supplies being disrupted across an entire district.

One unforeseen consequence of the good vaccine distribution system is that vaccine cold chains are regularly used for other goods. For instance, the Central Public Health Laboratory openly acknowledged that laboratories use vaccine refrigerators to keep its reagents cool, even though this is strictly prohibited.

JMS sells a wide range of drugs and goods, with an emphasis on basics and the essential medicines list. Its biggest product lines are sundries i.e. basic supplies such as gloves, masks, antibiotics, and anti-malarials including quinine. It does not sell ARVs, since it does not wish to compete with donor projects. It sells some medical equipment, though sales are modest—about six percent of their total business, or roughly $2.4 million. They will install equipment and can do basic service as well.

Drugs and equipment at the JMS are often more expensive than at the NMS. However, the JMS has significant advantages in terms of service, availability, and convenience. For instance, regular JMS customers get automatic business credit,[24] and can use their "Pick-Check-Pack" system, which allows fast ordering by e-mail or fax. There is also a perception that JMS goods are of a higher quality. Since the JMS and the NMS are drawing from the same sources, this is unlikely though JMS drugs may be younger[25], but the perception is real nonetheless.

For consumers, the largest drawback to JMS is that it does not provide transport. Buyers must come to the JMS facility in Kampala with their own vehicle; the JMS' responsibility ends as soon as the goods leave the premises. Buyers pay all transportation costs and bear the risks for bringing the goods to their final destination. The JMS, nonetheless, has clients across the entire country.

## WILLIAMS STREET (DRUG IMPORTERS AND WHOLESALERS)

Uganda has a vibrant pharmaceutical and medical supply importation sector. The local manufacturing sector can produce only a handful of drugs; everything else—by volume about 75–80 percent of all drugs consumed in the country—must be imported. This is done by between 30 and 40 small to medium-sized firms.[26]

In most countries, including most developing countries, drugs move from manufacturers and importers to retail pharmacies and hospitals by means of drug distributors. These three functions—manufacturing/importing, distribution, and retail sales/final use—are normally divided fairly sharply. Distributors handle warehousing, invoicing, transport, collection, and demand management. Around the world, drug and medical supply distributors typically have a high level of consolidation (a medium-sized country may have just two or three) and tend to be full-service (i.e., in many countries a typical retail pharmacy can get all its needs from a single distributor). Distributors also tend to enter into long-term agreements with both suppliers and end buyers.

Uganda is very different. The shape of its supply chain is unusual, and the market functions are divided quite differently from the norm.[27] There are no distributors as such. Williams Street companies do their own importing and have warehouses, but generally are not responsible for transport (purchases at Williams Street are

24 The JMS varies its business credit: long-term customers get 60 days, private hospitals get only 30 days, while retail pharmacies are usually denied credit entirely and forced to pay cash. The JMS is willing to extend payment dates further when customers have cash flow problems, but it has cut customers off for nonpayment. In 2008 the JMS had to write off about 120 million shillings or $60,000 of bad debts. Credit with the government is a special case; the government's credit is generally good, but payment may take many months, and individual buyers (i.e., a large referral hospital) may accumulate hundreds of millions of shillings of debt

25 The JMS will not accept drugs that have less than 75 percent of their shelf life left.

26 Most of these are located on or near Williams Street in downtown Kampala, so "Williams Street" has become the slang term in the sector for all of them collectively.

27 Insofar as Uganda has distributors, the NMS and the JMS fill this role. In fact, the NMS and the JMS are probably the reason Uganda's private sector supply chain has evolved in such a strange way. A number of other former British colonies have an NMS equivalent, but the NMS/JMS combination may be unique to Uganda.

typically ex warehouse) or for demand management. No single company on Williams Street is full service, as each provides only a limited number of drugs and supplies. Therefore, any clinic or retail pharmacy that wants to fill its needs must go "up and down Williams Street," making multiple stops to buy different goods. In many cases, only a single company on Williams Street may sell a particular item; unsurprisingly, in these cases prices tend to be quite high. At the same time, popular products such as antibiotics and painkillers are sold by multiple vendors, so prices and margins on these tend to be low.

This somewhat unusual division of market roles has a number of odd consequences. The fragmentation of the market means that simply procuring a full line of drugs for a retail pharmacy is a major task. Retail pharmacy owners say that they must spend several days a month on this, a job that in many other countries is handled in an hour or two by ordering with the local distributor. On one hand, prices on basic items are kept relatively low; on the other, the system is very vulnerable to fluctuations in supply and demand. Williams Street offers a surprisingly wide range of products, including diagnostics and test kits, reagents, surgical instrument sets, and veterinary products. But most of the Williams Street companies are very undercapitalized, so they cannot hold large amounts of inventory in stock, nor can they easily expand into new product lines.

Most of the Williams Street firms are small and medium-sized enterprises (SMEs) with between 10 and 50 employees. The majority are owned by ethnic South Asian Ugandans or by foreigners. A few own retail pharmacies in Kampala, but most are strictly importers and wholesalers. No single company has as much as 15 percent of the wholesale market; the five or six largest together have about 40 percent.

Williams Street firms face a number of challenges. In addition to competing with the NMS and the JMS, they suffer from very limited access to credit, weak IT and inventory systems, and lack of access to qualified staff. Desirable employees such as accountants and chemists tend to move easily from one Williams Street address to another. Cash flow problems are common,[28] which makes it difficult to obtain business credit; Williams Street prefers cash whenever possible.

Williams Street is supposed to source only from NDA-approved factories. In the past, this was a major issue, as some of the Williams Street importers were willing to purchase drugs and supplies on the grey or black markets. In recent years, drug importers have become more willing to obey the law on this point.[29]

Williams Street has a complex relationship with the NMS and the JMS: they are competitors, but both the NMS and the JMS sometimes source from Williams Street importers. Williams Street companies express frustration with the NMS for its slow and clumsy procurement. The larger firms want to participate in NMS tenders, but are unhappy with the amount of time and effort that is required.[30] The JMS is respected for its efficiency, and for being relatively easy to sell to, but is resented for its "unfair" pricing: "It's very hard to compete with a religious institution that doesn't have to show a profit."

Over time, there has been a gradual trend towards consolidation; there are fewer companies on Williams Street today than there were five years ago, and most expect that in the future there will be fewer still. The smaller and weaker importers can be crippled by a single bad quarter, and are then vulnerable to being bought out or driven out of business by stronger competitors. Two or three of the largest Williams Street enterprises are beginning to look like embryonic distributors: they have warehouses and delivery trucks, can afford to keep a couple of months' inventory on hand, can make large, long-term contracts with local manufacturers, and can offer business credit to customers.

## LOCAL MANUFACTURERS

Uganda has a small but active pharmaceutical manufacturing sector.[31] Virtually all of its output is consumed locally. Uganda has no pharmaceutical exports worth mentioning.[32] Relatively

28 When business credit is given, the average payment time is well in excess of 60 days.

29 As one interviewee put it, "Today, if you buy from Williams Street, the odds are pretty good. You're probably getting what it says on the label."

30 One of the larger Williams Street firms has a full-time employee doing nothing but NMS tenders.

**PROCUREMENT KICKBACKS**

The issue of kickbacks came up in a number of contexts, but most repeatedly in discussing procurement *by* public hospitals *from* private suppliers—i.e., Williams Street. This issue arises when the NMS cannot supply a hospital's needs, which happens fairly regularly. The hospital is then free to source from the JMS or elsewhere.

To simplify, public hospital staff accuse Williams Street suppliers of offering them kickbacks in return for selling drugs at inflated prices. Williams Street interviewees, without exception, protest that the truth is exactly opposite: hospital staff members demand kickbacks from them in return for buying their particular drugs. No interviewee would admit to giving or taking kickbacks, but everyone agreed that others were doing it.

little is purchased by the NMS, because of procurement issues.[33] Some goes to the JMS, to private hospitals, and to donors, but most is taken up by Williams Street.

Uganda's manufacturers can produce a wide range of basic and essential pharmaceutical products, including antibiotics, antiseptics, and painkillers. However, most have fairly limited production capacities, and no ability to rapidly expand. Most use old equipment[34] and have little or no access to credit for upgrading. Margins tend to be quite low, and the sector as a whole is undercapitalized. The manufacturers made a concerted effort several years ago to get protective legislation passed, raising tariffs on some drugs, but it was revoked after just a few weeks. The sector also suffers from a particularly painful shortage of trained personnel, especially chemists and pharmaceutical engineers.[35]

## THE PFP SECTOR

Uganda has a vibrant Private for-profit sector, including private hospitals, clinics, doctors' offices, and retail pharmacies. The relationship with the public sector is complex, but for supply chain purposes the two are complementary. The PFP sector generally does not use NMS, sourcing instead from JMS or directly from Williams Street. A few of the larger hospitals and clinics source directly from local manufacturers, but this is not typical.

The PFP sector is in some ways better off than the public sector. Salaries tend to be higher, management tends to be tighter, and dramatic breakdowns of the supply chain are less common. However, it shares in the common problems of poor training, brain drain, and corruption. The private sector is also challenged by small size—most private actors are small, single doctors or small local clinics—lack access to finance, and general severe undercapitalization. Clinics, pharmacies and small local hospitals tend to run on a shoestring, and often have severe cash flow problems. In combination with poor training and inventory control, this contributes to stockouts, which are nearly as common in the private as in the public sector.

At the time of publication, no Ugandan manufacturer is WHO certified, although Quality Chemicals is in the process. The manufacturers have an industry association—Uganda Pharmaceutical Manufacturers—which has been fairly active in lobbying the government and in trying to coordinate member actions.

## RETAIL PHARMACIES

The retail pharmacy[36] market is extremely fragmented. About 80 percent of all drugstores are sole proprietorships; there are only a few small chains, the largest of which—Vine Pharmacy, in Kampala—has just nine stores and 60 employees. This is in large part because retail pharmacies are undercapitalized; very few can obtain bank loans or formal credit.

Like every other part of the supply chain, pharmacies are undercapitalized. They have no access to formal credit; banks have no understanding of the retail pharmacy business. They are also very vulnerable to the general fluctuations in price and demand.

31 There are 6 medium-sized manufacturers and 8 or 10 small ones; most of the small ones are producing just one or two products. Since most of the APIs are imported, strictly speaking most of the factories are formulators rather than manufacturers. The factories must import not only APIs but also pharmaceutical sugar and starch. This may seem odd given that Uganda produces plenty of sugar and corn, but the manufacturers have not been able to find a local processor who can consistently and reliably produce pharmaceutical-grade products. They have also been unable to source primary packaging (i.e., packaging that actually touches the drug). This means that everything but secondary packaging must be imported, adding significantly to the final price.

32 Uganda does export raw Artemisia, which grows in the south. It is exported to India to be processed into artemisin.

33 The larger local manufacturers can deal with the tender process, but still dislike the NMS because it has a history of not paying its bills on time. One manufacturer stated that this has improved in recent months.

34 For instance, outside of Quality Chemicals, no local manufacturer uses electronic control systems; they are electrical or mechanical. This is because, although electronic control systems are much more efficient, nobody in the country can maintain or repair them. Equipment breakdowns are fairly common; even when the manufacturer can do its own repairs, this makes it difficult to guarantee continuous production and timely delivery of large batches.

35 Two manufacturers were asked how many pharmaceutical engineers there were in Uganda. Both gave similar answers: "Depending on how you define it, between two and six."

36 Uganda draws a distinction between pharmacies and "drug shops." Drug shops sell only over-the-counter drugs; they do not fill prescriptions. The NDA regulates drug shops as well. The NDA has a policy of encouraging drug shops to open in villages (where there may be no access to drugs at all) and discouraging them from opening in cities and larger towns (where they will compete with pharmacies).

### QUALITY CHEMICALS

Quality Chemicals (QC) is Uganda's newest, and by far its largest, pharmaceutical manufacturer. Its large, modern, $38 million facility opened on the outskirts of Kampala in October 2007. QC employs 180 people and could, if operating at full capacity, produce about as much as the next three largest local factories combined.

QC is owned partly by Sipla, a major Indian generic manufacturer, and partly by a consortium of local investors; the Ugandan government is a minority shareholder. It plans to manufacture a wide range of drugs both for Uganda's internal market and for export, starting with antimalarials and ARVs, both of which are in high demand. So far, it has been prequalified by the International Committee of the Red Cross and by UNICEF, with WHO qualification still under way at the time of publication. The government of Uganda, in order to encourage QC's investment, granted it an exclusive seven-year sourcing guarantee for ARVs and antimalarials. This has generated some criticism, as QC's drugs can be more expensive than the same doses purchased internationally. QC says this is because it is still paying start-up costs and has not yet achieved economies of scale.

In 2008 QC had gross sales of about $30 million, all to the Ugandan government. In 2009 it began selling to the JMS. In the long run, it wants to sell to donors and also to export drugs across all of East and Central Africa. However, the facility is running at a small fraction of its potential output, and QC is certainly not yet in the black.

QC machines are top quality, and the first batches of production have met all quality standards. Some aspects of its relationship with Uganda's current government may be murky, but that is hardly surprising. Insofar as the team's research can tell, QC looks like a high-risk, high-gain roll of the dice by a large international drug company. If it succeeds, Sipla and its friends will have the only advanced pharmaceutical manufacturing facility between South Africa and Egypt, and will be well placed to sell expensive drugs to donors and NGOs across a large chunk of the continent. The obstacles and challenges to this plan are obvious enough, but QC's owners seem serious.

The NDA regulates retail pharmacies, but unevenly. On one hand, laws on dispensing Schedule B drugs without a prescription are not enforced. (See below.) On the other hand, the NDA pays close attention to drugstore advertising, and also monitors the distribution of pharmacies across Kampala. If a particular neighborhood is seen as having "enough" drugstores, the NDA may resist licensing a new one. Pharmacy owners and operators complain that the NDA's regulation is unreasonably restrictive and also inconsistent.

## SUPPORTING INSTITUTIONS

### CENTRAL PUBLIC HEALTH LABORATORY (CPHL)

The CPHL is responsible for coordinating laboratory activities, both public and private, across the entire country. It trains lab workers, sets guidelines and standard procedures, watches for disease outbreaks, and administers a credit line for reagents and other lab supplies. It has a budget of $9 million per year, which by Ugandan standards is quite respectable. Some of this funding comes from the U.S. Center for Disease Control.

The CPHL is also tasked with collecting and analyzing data nationwide, but it lacks the capacity to do this. There are about 1,500 labs across Uganda, of which about 800 are at public hospitals and clinics and the rest at private, NGO, and PNFP facilities.[37] The CPHL simply cannot collect information from all of these effectively and analyze it. The CPHL does attempt to quantify data as best it can, and prepares a procurement plan for lab supplies for the NMS.

The CPHL is also supposed to conduct lab inspections, but because of resource limitations

37 There are many lab facilities at private hospitals, but very few private, for-profit labs.

### UNEXPECTED CONSEQUENCES: THE CLINTON FOUNDATION VS. MEDICAL EQUIPMENT FIRM

One of the most successful local medical equipment firms is a private, closely held company based in Kenya that imports several million dollars of lab equipment each year. The company has adopted a successful business model that emphasizes service and reliability, including warranties and technical support. A large part of its revenue comes, not from the lab equipment sales, but from sales of reagents to keep the equipment running. The company offers its buyers annual contracts to supply them with reagents, producing a steady stream of income.

Unfortunately, the firm was nearly driven out of business in 2006–2007 when the Clinton Foundation began offering some of the most popular reagents for free. A number of buyers broke their contracts, as the free reagents were just too attractive. The firm was forced to take a bridge loan, and seriously considered withdrawing from Uganda. The Clinton Foundation seems not to have realized how large an impact their actions would have; it appears the foundation thought that the reagent supply contracts were of minimal importance, since the company was "really" a medical equipment supplier.

it can only do these very occasionally. Outside of Kampala, labs may go years between inspections or may never be inspected at all. The NDA is responsible for quality assurance of lab reagents, but otherwise no one is inspecting lab equipment or supplies.

## DONORS

The relationship between donors and supply chains is complex, and a detailed discussion is beyond the scope of this chapter. That said, donors have an immense impact, both positive and negative, on the supply of drugs and medical goods in Uganda. The positive impact is obvious enough: donors either subsidize goods or simply pay for them outright, thus making them available to millions of Ugandans who could not afford them otherwise. Donor money also helps support the private sector. Williams Street depends in large part upon donor purchases and sales to donor-funded projects. The 2 percent "verification fee" for donated medicines, annoying though it is to the donors, is probably keeping the NDA afloat. And donors have given direct assistance to the public sector portions of the supply chain, especially the NMS and the Ministry of Health.

On the other hand, donors have created vast distortions in the market. Donors give away or subsidize drugs that the private sector would like to sell. Even when donors purchase drugs from local producers or wholesalers, they tend to buy in bulk, depressing margins. While this is sometimes unavoidable, donors add an additional level of uncertainty to a business environment that is already extremely unpredictable and difficult.

## COMPETITION AUTHORITY

There is no private sector-wide competition authority in Uganda. Though some legislation has sought to minimize anticompetitive behavior in certain industries, no common definition of key competition policy terms exists. The NDA takes some ad hoc actions to regulate competition at the retail level i.e. by discouraging new pharmacies from opening where there are already many, acting to keep drug shops in the villages, and the like.[38] No formal entity seems to be regulating competition on Williams Street. Several interviewees mentioned collusion and other trade-restraining practices there, but it was not possible to investigate or confirm these in the time available.

## DISPENSING DOCTORS

In theory, most doctors are not allowed to dispense most drugs. The law states that doctors cannot dispense any drugs except for a short list that includes vaccinations, injections, topical antibiotics, and antiseptics. In practice, this is often interpreted very narrowly or simply ignored. Many doctors have formed close

38 It is not clear that NDA has the legal authority to do this. It is also not clear that it's a good idea from a policy perspective. This is probably not something the drug regulator should be doing; even if it was, it's a diversion of scant resources away from more important concerns.

associations with local pharmacies; many others, especially in private clinics, simply sell drugs direct to their patients. Regardless of the legality of associations between doctors and pharmacists, it is a fairly widespread practice.

### PNFPs

Religious PNFPs play an immensely important role in delivering health care; they support more than 40 hospitals and roughly 500 clinics and other small health care units, and may provide as much as a quarter of Uganda's total health care. A few of the largest PNFPs do some of their own drug and supply procurement, reaching out to local manufacturers or—more rarely—overseas. However, the vast majority of them source their drugs and supplies from the JMS and Williams Street.

### PHARMACISTS

Pharmacists in Uganda are required to have a medical degree plus additional training. As a result, they are quite rare; there are only about 300 in the entire country, or less than one per 10,000 Ugandans. Unsurprisingly, most pharmacists hold two or three jobs at once.

By law, every private pharmacy must have an associated pharmacist who supervises it; in practice, the association is quite loose, and the pharmacist may only show up from time to time to collect a paycheck. Most of the actual work is done by dispensers (who have a special diploma) or pharmaceutical orderlies (who have a certificate). In some lower-level clinics, dispensing may be done by nurses and midwifes.

A new pharmaceutical school, dedicated to producing new pharmacists and dispensers, is expected to open at Makarere in 2010.

## SOCIAL DYNAMICS

### INCOME INEQUALITY

Uganda suffers from significant inequalities of wealth and income,[39] and this has had a significant impact on the delivery of goods in the health sector. Poverty is a major issue in the demand for pharmaceuticals. Approximately 40 percent of Uganda's population lives on less than $2 per day. These people are often unable to afford most drugs; even very basic and cheap generics may be out of reach. The poor are also especially sensitive to pricing; raising the cost of a drug by just a few tens of shillings may cause a noticeable drop in demand from low-income buyers.[40]

In Kampala, middle class and wealthy Ugandans have access to a parallel, higher-quality health care system of private hospitals and clinics. While this taps into the same supply chains as the rest of the system, higher-income Ugandans are using far more drugs, medical supplies, and laboratory tests per capita than the rest of the country. In fact, there seems to be a rough, but clear, correlation between drug consumption and income in Uganda. This in turn suggests that if incomes continue to rise in Uganda, an expanding middle class will demand more access to drugs, placing more strain on an already shaky supply chain.

### FEAR OF COUNTERFEIT DRUGS

Fear of counterfeit drugs is a major issue in Uganda. While there is no formal recent study assessing the impact of counterfeit drugs,[41] there is a widespread perception that it is a serious problem. Whether this is true or not, it definitely affects the behavior of both sellers and consumers. The JMS, for instance, emphasizes its honesty and reliability and the high quality of the products sold there. Meanwhile, fear of counterfeit drugs helps drive strong local drug preferences: drugs from Europe are greatly preferred to drugs from India or drugs manufactured locally in Uganda. Patients will sometimes ask for a "better" drug if offered one from India.

The NDA is responsible for combating counterfeit drugs. There is general agreement that the situation has improved in recent years, partly because of the NDA's efforts and partly because Williams Street has become somewhat more cautious.

39 According to the United Nations, Uganda's Gini coefficient is 42.6—high, but not unusual for a developing country at Uganda's level of income.

40 It can also have a dramatic effect on patterns of drug consumption. Poor patients often want to purchase drugs one pill or one dose at a time when possible, and are very likely to drop a course of treatment before it is complete in order to save money.

41 There are a number of small-scale studies showing problems with particular drugs.

## INVENTORY CONTROL AND LEAKAGE

Inventory control is a problem at every level of the supply chain, but it is particularly bad in the public sector. Many of the smaller public clinics have inadequate or absent IT, and many clinics and hospital pharmacies either do not use their stock cards properly or do not have stock cards at all. More generally, much of the public sector—even level 4 clinics and referral hospitals—exhibit poor inventory control practices.

Many interviewees stated that there is a problem with leakage of drugs and medical supplies out of public hospitals and clinics and into the private sector. There are also public statements to this effect; for instance, in 2008 the Ugandan Minister of Health announced that as many as half of all medicines bought for use in the public health system were being siphoned off by health workers and resold to private clinics or pharmacies. Part of the problem is that in many cases, the same doctors and other staff are working in both public and private clinics. It is both tempting and, in most cases, easy for a doctor to move drugs and supplies out of the public dispensary and over to his clinic. The MoH has attempted to grapple with this problem in a variety of ways, most recently by requiring special labeling and packaging for drugs that are to be dispensed in hospitals.

## ADVERTISING

Advertising for drugs is almost non-existent in Uganda. There are no multinationals to spend money on advertising for individual branded drugs, and the NDA sharply restricts the ability of pharmacies to advertise.[42] Manufacturers and wholesalers do not see the need, as the sector is small and everyone knows everyone. Also, smaller businesses are reluctant to engage in flashy advertising, i.e., billboards, for fear of attracting attention from the tax authorities.

## PRESCRIPTION DRUGS AND RETAIL PHARMACIES

In theory, all prescription drugs require a prescription for purchase. In practice, if products


are not Schedule A (i.e., narcotics or central nervous system active medication), they are available over the counter. If available in stock, it is possible to walk into a drugstore anywhere in Uganda and simply purchase penicillin or Ritalin. The problem with this is not so much customers self-prescribing, but dispensers and clerks acting as doctors and diagnosing, prescribing, and selling all at once. Poor customers who cannot pay for a doctor's visit will go straight to a pharmacy and ask the person behind the counter for advice.[43] This is a real problem, but it is unlikely to change any time soon. The NDA lacks the manpower or capacity to enforce the prescription laws, and no individual pharmacy can do so without crippling its sales.

## SOUTHERN SUDAN

Since the 2005 peace accords, the Southern Sudan's medical sector has been undergoing rapid reconstruction. At the same time, the overland road link through northern Uganda has become much more secure, as rebel forces have moved out of the region. South Sudan is drawing heavily on Uganda's medical supply chains. The south has limited access to Sudan's

42 The NDA interprets the law as not allowing comparative advertisements or listings of particular drugs or medical products. Basically, all a pharmacy can advertise is its existence and its location.

43 In the words of one interviewee, the owner of a retail pharmacy, "Sometimes people have so much faith it's scary."

port on the Red Sea, and prefers to do its shopping in Uganda. It is not unusual to have a van from Sudan arrive in Kampala, spend a day on Williams Street,[44] and drive north the next day full of syringes or antibiotics. This can cause temporary shortages and contributes to the unpredictability of the supply chain. Presumably over time this will correct itself as Sudanese buyers become regular customers[45] and learn to place advance orders, but the situation is still fairly chaotic.

## REVERSE LOGISTICS

Uganda has major problems with reverse logistics and the disposal of medical waste. In theory, the Ministry of Health is responsible for expired drugs, while individual hospitals and clinics are responsible for other types of medical waste, and it is supposed to "sweep" for expired drugs at least twice per year. In practice, the Ministry of Health lacks the resources to effectively monitor the expiration of most drugs in the supply chain. Individual hospitals may give drugs to their DHO for return to the ministry and destruction, but smaller clinics and the private sector rarely do so. There is thus a widespread suspicion that expired drugs are leaking out of the system and being offered to the public.

The collection of other forms of medical waste is *ad hoc*. Used needles are generally disposed of correctly, by binding and caking, if only because this has been a high donor priority for many years. However, most hospitals lack incinerators. There is a common practice of simply putting waste in biohazard boxes and then giving it to a private waste collection service. Most hospitals and many clinics have placenta pits, which are designed for placentas and other non-contaminated forms of human medical waste. However, several interviewees stated that hospitals are using their placenta pits for general waste disposal, exceeding their design and possibly their capacity as well.

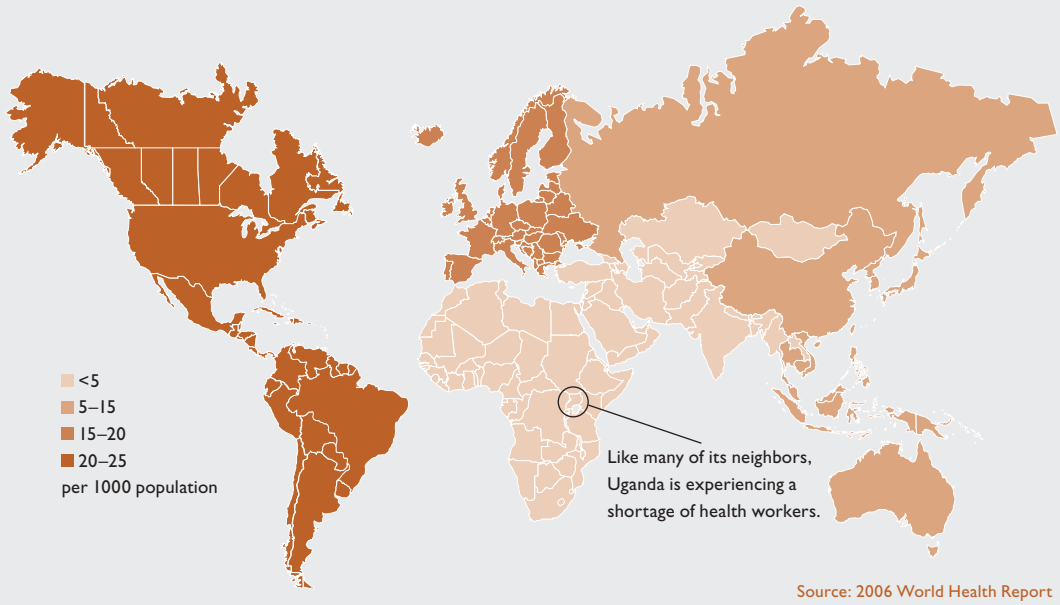
44 Few go to the JMS, because the JMS will not give them credit and does not always recognize their papers.

45 This is more or less what has happened with Rwanda and the north-eastern Congo, both of which import most of their drugs through Uganda.


# DEVELOPING HUMAN CAPACITY

For a country to achieve positive health outcomes for its citizens, it needs a strong health workforce—one that is sufficient in number, well trained, and appropriately distributed across the country. Despite recent efforts, Uganda's health workforce is characterized by a shortage of trained health professionals, poor working conditions, and an inefficient concentration in urban areas and at large facilities. Uganda's poor health outcomes are due in large part to these deficits.

**WORLD DISTRIBUTION OF HEALTH WORKERS**




Source: 2006 World Health Report

## HEALTH WORKER SHORTAGE

While Uganda's population has been steadily growing at an annual rate of 3.2 percent, the number of health professionals remains relatively flat, complicating the delivery of health services. The additional workload has put pressure on health human resources, compromised the quality of health care, and led to consumer claims of poor treatment from health workers. In addition, health workers have suffered disproportionately from HIV/AIDS. With an infection rate estimated at 6.7 percent of the general population,[46] the disease has taken the lives of many health workers in Uganda, while increasing the workload of those who remain.

Contributing to Uganda's health worker shortage, many medical doctors pursue public health careers as opposed to clinical disciplines. By choosing public health, medical personnel find jobs with higher salaries offered by the many donors and international NGOs in Uganda. As a result, there are too few clinical health professionals to service the population. In addition, a nearly exclusive focus on communicable diseases, such as malaria and HIV/AIDS, has left neglected

46 PEPFAR Uganda FY 2007 Country Operational Plan, *available at* http://www.pepfar.gov/about/82442.htm.

critical medical specialties including pathology, neurology, oncology, and anesthesiology.

### INTERSECTION OF THE PUBLIC AND PRIVATE SECTOR

Much of the infrastructure to educate, license, and regulate health human resources resides within the public sector. Three of Uganda's four medical schools and all of its regulatory bodies are public institutions. However, the private sector also features prominently in the training of health workers as PNFP facilities operate 20 out of 48 allied health and nurse training schools. Beginning with the training of health workers, both the public and private sector play an important role in shaping Uganda's health sector.

Recognizing Uganda's challenges in maintaining a strong health workforce, the donor community has provided the country with a great deal of resources, focusing on the public and private not-for-profit sectors. The PFP sector also plays an important role and represents an area of the health system that may bring long-term sustainability. However, while private practitioners are critical to enhancing the quality of and access to health services, many of them currently receive minimal regulation. Government oversight in this instance is crucial to ensure quality control for the protection of consumers.

A fully functioning health sector in Uganda should include strong health human resources in both the public and private sector. This section of the report will examine the path of health workers from their training to their placement within the public and private sectors and their ultimate contribution to Uganda's health system. Recommendations are also offered to further strengthen Uganda's health workforce to ensure positive health outcomes for all its citizens.

## LEGAL FRAMEWORK

### REGULATING ACADEMIC MEDICAL INSTITUTIONS

The Universities and Other Tertiary Institutions Act, 2001, established the National Council for Higher Education, responsible for regulating the establishment and management of higher education institutions, including medical, dental, and pharmacy schools. With the advent of private medical training institutions, a relatively new development in Uganda, the role of the council has significantly expanded.

With regards to the optimal location of other medical training schools, following a protracted debate between the Ministry of Health and the Ministry of Education and Sports, the Business, Technical, Vocational Education and Training Act was passed in 2008 and granted responsibility for nursing, midwifery, and allied health professional courses to the Ministry of Education and Sports. The statute establishes the Industrial Training Council, which is responsible for all related policy making and grants the power to establish by statutory instrument examination boards for the areas of nursing, midwifery, and allied health professional[47] courses. The Education (Pre-Primary, Primary and Post-Primary) Act, 2008, also addresses the development and regulation of educational institutions, including the management of schools by the Ministry of Education and Sports as well as the process for establishing a private school.

### LICENSING AND REGULATING MEDICAL PROFESSIONALS

The Uganda National Exam Board Act, 1983, established the National Exam Board, which is responsible for all qualifying exams for health professionals in the areas of pharmacy, allied health professions, nursing, and midwifery.[48] The National Exam Board administers exams and passes the results to professional councils for registration.

Once students pass the relevant exams, they are ready to be registered in their health professions. The Allied Health Professionals Act, 1996; Medical and Dental Practitioners Act, 1998; Nurses and Midwives Act, 1996; Pharmacy and Drug Act, 1970 govern the licensing of health professionals. Each act establishes

47 Allied health professionals include: medical clinical officers, orthopedic officers, orthopedic technicians, psychiatric clinical officers, pharmacy technicians, physiotherapists, occupational therapists, radiographers, laboratory technicians, laboratory technologists, ophthalmic clinical officers, anesthetic officers, public health dental officers, health inspectors, health assistants, vector control officers, and scientific officers.

48 Medical doctors and dentists are not required to take qualifying board exams. They can register in their professions following five years of study and one year of internship.

a regulatory council that is mandated to register and license the relevant cadre of health professionals and monitor the profession. The relevant laws endow the councils with the responsibility of enforcing standards in the medical sectors, including validating continuing education requirements, and pursuing individuals who have failed to maintain regular licensing. In reality they have neither the financial nor the human resources to accomplish this task with any rigor. As such, there is no real mechanism to revoke licenses, and many health professionals practice without a valid license.

## PHARMACY

The Pharmacy Council faces additional challenges, as it is not an official legal entity and is operating without a statute. An effort to revise the Pharmacy and Drugs Act of 1970 has been ongoing since 1996. The *Pharmacy Profession and Pharmacy Practice Bill, 2006 (DRAFT)* has been delayed and is still with Parliament. The bill's proponents wish to separate regulation regarding the distribution of drugs, which is subject to many international norms, from the regulation of pharmaceutical professionals, which can be more reflective of the local context. Under the current legislation, the National Drug Authority has a role in both.

## TRADITIONAL AND COMPLEMENTARY MEDICINE

Operating outside of any regulation is the traditional and complementary medicine (TCM) sector. This sector includes herbalists, traditional birth attendants, traditional bonesetters, and other traditional healers. In an effort to enhance regulation, a policy was drafted, *Traditional and Complementary Medicine: National Policy and Implementation Guidelines for Traditional and Complementary Medicine Practitioners, Sept 2006 (DRAFT)*. However, this bill is still in Parliament without strong proponents to usher it through. As a result, there remains no comprehensive legal framework to regulate practitioners of traditional and complementary medicine in Uganda.

**KEY LAWS**

- Universities and Other Tertiary Institutions Act, 2001
- Business, Technical, Vocational Education and Training Act No. 12 of 2008 (BTVET Act, 2008)
- The Education (Pre-Primary, Primary, and Post-Primary) Act, 2008
- Uganda National Examinations Board Act, 1983
- Medical and Dental Practitioners Act, 1998
- The Allied Health Professionals Act, 1996
- The Nurses and Midwives Act, 1996
- Pharmacy and Drugs Act, 1970
- Employment Act, 2006
- Labor Disputes, Arbitration and Settlement Act, 2006
- Occupational Safety and Health Act, 2006
- Health Service Commission Act, 2001
- Labor Unions Act, 2006
- Uganda Migrant Workers Abroad Statutory Instrument
- Constitutional Amendment Act, 2005
- Immigration Act
- The Code of Conduct and Ethics for the Uganda Public Service
- *Pharmacy Profession and Pharmacy Practice Bill, 2006 (DRAFT)*
- *Traditional and Complementary Medicine: National Policy and Implementation Guidelines for Traditional and Complementary Medicine Practitioners, Sept 2006 (DRAFT)*

## REGULATING THE FORMAL WORKFORCE

All professionals employed in the formal economy are governed by the country's labor laws. The Employment Act, 2006, sets minimum standards, including employee rights and duties, payment of wages, disciplinary policies and termination, and continuity of employment. Additional acts, such as the Labor Disputes, Arbitration and Settlement Act, 2006, governs dispute resolution while the Occupational Safety and Health Act, 2006, governs safety standards. Several other policies have been put into place to enhance the experience for workers, including the HIV/AIDS workplace policy.

While the legal framework is in place, in many instances, the law is not evenly implemented.

In the public sector, the Health Service Commission Act, 2001, established the Health Services Commission, which is responsible for recruiting and appointing health workers at the Ministry of Health headquarters, the two national referral hospitals, and the 11 regional referral hospitals. The commission also writes the guidelines for the recruitment of health workers in the districts. The Ministry of Public Services is responsible for setting salaries of health workers as well as schemes of service and performance evaluation systems. Despite a recent salary increase for public health workers, salaries remain low and are a de-motivating factor among the health workforce. The government's attempt to attract health workers to hard to reach areas with additional benefits has been largely unsuccessful.

The Labor Unions Act, 2006, grants employees the right to organize and lays out the process for registering a labor union. The two primary national trade unions are the National Organization of Trade Unions (NOTU) and the Central Organization of Free Trade Unions (COFTU). Despite being the largest labor federation, NOTU counts as members only approximately five percent of the formal workforce. While strikes are legal, in reality they are muted by bureaucratic red tape and restrictions.

## REGULATING THE INTERNATIONAL MOVEMENT OF HEALTH WORKERS

Uganda experiences a significant level of movement of health workers across its borders. Higher salaries and better working conditions have attracted Ugandans to places like the United Kingdom and South Africa, as well as to neighboring countries such as Rwanda and Kenya. Realizing that the migration of labor is inevitable and that the resulting remittances are desirable, the Ministry of Gender, Labor, and Social Development has established an External Employment Unit to help Ugandans go overseas legally. The Uganda Migrant Workers Abroad Statutory Instrument was implemented with the objective of promoting equal and fair employment for Ugandans working overseas. Uganda also passed the Constitutional Amendment Act in 2005 allowing for dual citizenship, an added incentive to encourage movement.

In the reverse direction, foreign health workers also supplement Uganda's workforce within the country. Foreign health workers are subject to all provisions of the Immigration Act regarding entry requirements. They then register for medical licenses following the same process as nationals, though they retain a temporary license until they become Ugandan citizens. Foreigners submit their credentials and application to the relevant council which then conducts a review, requests additional information as needed, and awards the license. There has been discussion of establishing an exam for applicants coming from unknown universities, but this has not yet been done. The relative ease with which foreign medical workers can register to practice in Uganda has facilitated the contribution of many affiliated to the mission-run PNFP facilities as well as the private sector, which is seeing an increasing number of foreigners.

### REGULATING PRIVATE PRACTICE

While the Code of Conduct and Ethics for the Uganda Public Service forbids a public officer from holding two jobs at the same time, in reality the majority of health professionals in Uganda engage in dual practice to supplement their low public sector salaries. According to most health practitioners, without officials turning a blind eye to dual practice in Uganda, the public health sector would crumble. Public health workers, unable to live on a public sector salary, would abandon the public health system and possibly the country altogether.

The salary structure, therefore, leads to dual practice, itself not a negative phenomenon. Additional private practitioners increase access to health care and take pressure off public sector facilities by siphoning off patients who are willing and able to pay for service. Conflicts of interest may arise, however, as a result of minimal oversight and supervision within the public sector, which leads in some instances to individuals putting their private practice ahead of their responsibilities in their public sector position. In addition, public health workers are sometimes perceived as using their public sector position to protect or enhance their private sector jobs. Enforcing a law against dual practice in Uganda is not the way to improve the health system, however, unless it is accompanied by a dramatic increase in salaries, benefits, and working conditions in the public sector. A more rational approach would be to ensure accountability at public sector facilities during work hours, cutting down on absenteeism and enabling practitioners to service patients in private clinics after hours.

## IMPLEMENTING INSTITUTIONS

### LICENSING AND REGULATION OF HEALTH HUMAN RESOURCES

The four professional councils—Uganda Medical and Dental Practitioners Council, Nursing and Midwifery Council, Allied Health Professional Council, and Pharmacy Council—register and license all medical professionals. By law, the councils are semi-autonomous and meant to be independent of the Ministry of Health. However, due to limited resources, three of the four councils are located at the MoH, compromising the councils' mission of independent regulation of professionals in both the public and private sectors. The Nursing and Midwifery Council has secured its own premises, primarily because of a membership base that is significantly higher than the other councils, which provides more revenue from membership fees. The councils are responsible for regulating their respective professions, including registering and licensing of professionals, ensuring continuing professional development (CPD), and upholding educational standards and ethics. While the councils have increased their ability to regulate medical practitioners, they have limited capacity to enforce standards and assure quality.

Each council faces a deep lack of financial and human resources. According to the law, the councils' funding should come from periodic appropriations from Parliament, grants, donations, fees, and revenue from services. Because of widespread non-compliance with licensing, the councils do not collect the necessary revenues that could begin to give them independence from the MoH as well as the resources to fulfill their full mission. In addition, funding from Parliament has fluctuated, compromising the stability of the councils.

The government's *Annual Health Sector Performance Report, Financial Year 2007/2008* acknowledges that each of the four councils are understaffed and underfunded. They have no presence outside of Kampala and few linkages in the districts. While an arrangement was made with district health officers who were to work on behalf of the councils outside of Kampala, this relationship has not borne out due to a lack of financial support and oversight from the councils.

After the initial registration, annual re-licensing is required for all health professionals except nurses and midwives who are required to

re-license every three years. Because the councils have minimal capacity to operate in the regions, applicants must bring the relevant documents to the registrar in Kampala. Health workers have no option but to arrive in Kampala with their documentation and return three months later to pick up their license when it is ready. Facing what is in many cases a long and expensive journey to Kampala and minimal threat of enforcement or punishment for expired licenses, many health workers neglect to keep their license current.

Because there is minimal self-regulation within the industry, weak regulatory bodies result in a lack of quality control of health workers, which in turn compromises the quality of health care. The councils recognize their weakness and have recently benefited from technical assistance from *USAID's Capacity Project,* which has introduced a certification and licensing information system that has improved the quality of record keeping. This has provided the councils with accurate data that can help with enforcement as well as workforce planning exercises.

## HEALTH HUMAN RESOURCES PLANNING

### INTERMINISTERIAL PLANNING

The Ministry of Health leads a Human Resources Technical Working Group, which includes representatives from the PNFPs, the Ministry of Local Government, the Ministry of Public Service, the Ministry of Education and Sports, district representatives, and development partners. This has provided a forum for health human resources planning. Recognizing the need to better manage the country's health workforce, the Ministry of Health developed the Uganda Human Resources for Health Strategic Plan 2005–2020 to move forward the 2006 HRH Policy and the Health Sector Strategic Plan (HSSP) II, which also addresses the development of health human resources. The development of the plan was a positive step and incorporated the input of the Ministry of Education and Sports, the Ministry of Public Service, and the Ministry of Local Government. While it considered the health workers in the PNFPs, it did not take into account PFPs. It also left out of the process the medical training facilities, which are responsible for producing health workers. Ideally, the planning process would take a comprehensive look at the entire health workforce in order to develop a more accurate understanding of the current situation and consequently develop government policies that stimulate production and placement of health workers.

**STAFF IN REGIONAL REFERRAL HOSPITALS 2007–2008**

| Position | % Filled |
|---|---|
| Doctors | 46% |
| Dental | 76% |
| Pharmacy | 53% |
| Nursing | 87% |
| Allied Prof. | 71% |
| Admin | 56% |
| Support | 61% |

Source: Annual Health Sector Performance Report, 2007/2008

While the plan was a positive step forward and lays out workforce projections, it has not been fully implemented and there continues to be a health worker shortage, particularly in remote districts. According to the MoH personnel office, only 50 percent of approved positions are filled. While donors have supported health workers in rural districts, the government may also consider expanding hardship allowances. Because of budgetary pressure, public hospitals are understaffed, including the national referral hospital, Mulago, which is operating on 34.8 percent of optimal funding.[49] The incorporation of a Human Resources Information System (HRIS) at the MoH with the help of *USAID's Capacity Project* was an important development that will help MoH to put plans into operation. There remains a further need to develop the capacity to analyze and apply information, engaging in evidence-based decision making. To further implement the strategic plan, the

49 *Annual Health Sector Performance Report Financial Year 2007/2008.*

MoH is seeking a World Bank loan to develop a bureau to monitor employment gaps and align students to jobs as they graduate.

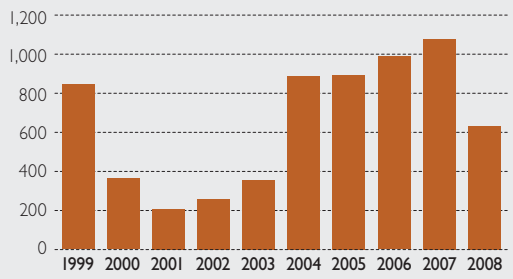
The MoH-led planning process may also benefit from addressing an organizational disconnect between the unit responsible for human resources development (i.e. training) and the unit responsible for personnel. These two units report to different offices, with no formal obligation to coordinate. Ideally, these two units should be formally linked, with identified need–informing actions taken to address gaps.

## DISTRIBUTION OF HEALTH WORKERS IN A DECENTRALIZED SYSTEM

Following decentralization in 1993, local districts gained the role of managing their health human resources. Because the districts continue to divide, there is a growing shortage of district health officers. The creation of more and more districts places stress on the health human resources system and increases costs. Districts manage their health human resources with varying levels of efficacy and coordination with the private sector. In some instances, districts are slow to recruit and hire, sometimes taking up to a year to recruit for one position.

There is a deep geographic imbalance of health personnel: 70 percent of doctors and dentists, 80 percent of pharmacists and 40 percent of nurses and midwives are based in urban areas serving 12 to 16 percent of the population.[50] The north, in particular, still suffers from severe health worker shortages with the majority of districts showing staffing levels below 60 percent.[51] Suffering from a conflict that lasted for two decades, the resulting poverty and health challenges have been an ongoing obstacle for economic development and have made it difficult to attract health workers to these depressed areas. Many health professionals do not desire to go up country and the districts often lack the resources to attract them with offers of lodging, transport, etc. In response, some districts have begun hiring cheaper nursing assistants, who have received three months of training, as opposed to enrolled comprehensive nurses, who have received three years of training. For many Ugandans, this has resulted in access to less qualified primary health professionals.

**NUMBER OF HEALTH ALLIED PROFESSIONALS REGISTERED BY THE HEALTH ALLIED COUNCIL 1999–2008**




Source: Health Allied Council

PNFPs have filled the gaps in some instances, though they also have difficulty in retaining staff. PFPs are the least prevalent, with very few incentives to attract private practitioners to depressed areas where the population has a limited ability to pay for health services. There are a few notable exceptions, such as the case of the International Hospital, which has partnered with several clinics up-country to offer in-network services to its members outside of Kampala. In these instances, members are able to utilize their insurance schemes in the in-network clinics. Future agreements will include a set of quality standards to which the clinic will need to adhere in order to remain in-network.

## TASK SHIFTING

In some instances, task shifting or the delegation of tasks to less specialized health workers, where appropriate can enhance health care coverage and leverage existing human resources. In making such staffing adjustments, it is critical to align the skills of the available practitioners with the needed procedures of the community. There is a growing consensus, for example, that midwives and clinical officers should be trained to perform Cesarean sections since they are primarily the medical professionals found up country. Such training would likely decrease the

50 *The Uganda Human Resources for Health Strategic Plan 2005–2020; Supplement 2009: A Health Workforce Crisis in Uganda: Time for Real Action.*
51 *Annual Health Sector Performance Report Financial Year 2007/2008.*

maternal mortality rate in areas where doctors are not present to perform such operations.

The government has shown a commitment to task shifting through support of allied health professional schools, which prepare clinical officers and others who could be groomed to take on more tasks that are traditionally assigned to medical doctors. Since its inception in 1998, the Allied Health Professional Council has been registering increasing levels of allied health professionals, with the exception of a dip in 2008. These individuals, along with nurses and midwives, provide a cohort of health workers who can be trained to manage increasingly difficult tasks in areas where access to medical doctors is limited or nonexistent.

## ACADEMIC TRAINING

Uganda's public and private institutions prepare health workers to work in both the public and private health sectors. While private education is a relatively new phenomenon in Uganda, older public universities such as Makerere dominate the landscape. While there are only four medical schools, Uganda now has over 40 nursing schools and 20 allied health institutions.

### ONGOING DEBATE BETWEEN MoH AND MoES

The Ministry of Health (MoH) and the Ministry of Education and Sports (MoES) have spent the last decade vying to control the country's medical training institutions. All medical training institutions were transferred from MoH to MoES in1998 under the premise that each ministry should focus on its core competencies. For the past decade, therefore, MoES has been responsible for basic and long-term in-service training of health workers. The planning and management of basic training of the health workforce (at the certificate and diploma level) is handled by the Department of Business, Technical, Vocational Education and Training within MoES, while the Department for Higher Education within MoES is responsible for programs of study at the degree and graduate level. There is little communication between the two Ministries.

While the Ministry of Education and Sports has been managing all medical training schools, the MoH has been lobbying for the return of the schools and the president has given a verbal agreement for the schools to move back to the MoH. However, this decision has not been implemented, creating uncertainty within each ministry about the future.

The ongoing debate regarding the place of the medical training schools has had some negative impacts. For example, in 2006, the Uganda Nurses and Midwives Council announced plans to administer a second examination to students who had already passed the exams given by the Uganda National Midwifery Examination Bureau in order to further qualify students' registration in the nursing and midwifery profession. This was not well received by students or the MoES and temporarily blocked the registration of nurses and midwives.

All parties will benefit from a conclusive resolution to the debate. Regardless of whether the training institutions are managed by the MoH or the MoES, closer collaboration is required between the two ministries. If the training institutions are to be moved back to the MoH, significant preparation and planning is needed in order to ensure a successful transfer, and to minimize impact on the production of formally certified health providers.

### MEDICAL SCHOOLS

The largest and most prestigious medical school remains Makerere, which produces approximately 100 doctors a year. The government's two other medical schools (Embarre and Gulu) and the private Kampala International University round out the roster of training institutions for medical doctors. In total, Uganda produces about 200 doctors per year, which will rise to 250 next year as Gulu University graduates its first class. This translates to one new doctor for every 120,000 people per year.

The quality of education is strong despite financial pressure on public institutions. Makerere Medical School has only filled 40 percent of current positions, for example. The curriculum emphasizes clinical practice with undergraduate students working up country in 43 districts. Makerere has transitioned to a problem-based curriculum that emphasizes group teaching. While the curriculum meets international standards, it is compromised by the lack of staff and tutorial rooms to support the methodology. With recent progress made in bringing broadband Internet to Uganda, it may be possible for certain courses or seminars from international experts to be online.

Despite the positive changes in the curriculum, medical students still lack courses in a few key areas. Very little training is offered in the area of management and business, a key skill set that would enable medical doctors to go into private practice. General management skills are also lacking in the public sector where medical professionals are often placed in administrative positions in public facilities. While arguably management professionals, as opposed to clinical professionals, should be placed in administrative positions, health workers would benefit from a basic set of management skills. A module on management training would better position all medical doctors after graduation.

At issue is also the limitation regarding specialization of study. For example, there is no oncology specialty offered in Uganda. As a result, there are only two oncologists in the country, both trained outside of Uganda and now based at Mulago Hospital's Cancer Research Institute. Their concentration at Mulago is advantageous in that they are able to take advantage of international partnerships and research opportunities while seeing patients at the nation's referral hospital. However, a total of two oncologists is largely insufficient to care for the entire population, leaving many cancer patients without access to specialized care.

## SCHOOL OF PUBLIC HEALTH—MAKERERE UNIVERSITY

The sole public health school in the country, Makerere School of Public Health, was created in parallel with the effort to decentralize the health system so that trained public health professionals could serve as district health officers. However, a slow uptake of recruits by the districts, combined with attractive salaries from donors and NGOs, have meant that the majority of public health graduates gravitate toward the NGO sector.

The school has incorporated a successful distance learning course where students spend two weeks a semester in Kampala and the rest of the year working independently with supervisors in the field. Approximately 50 people are enrolled in this program, which provides an attractive alternative for students who cannot travel to attend school in Kampala.

## PNFPs

PNFPs continue to make an important contribution in the area of training and operate 20 out of 48 health training schools in Uganda.[52] Many nursing schools are attached to PNFPs and have been established to help respond to the health worker shortage. Donor funding has supported

52 *Uganda Human Resources for Health Strategic Plan (2005–2020).*

health training institutions, some of which feature a bonding agreement with students. For example, Lacor Hospital in Gulu has its own nursing school where the government sponsored 16 students for the 2009–2010 school year. These students will be bonded to government service for two years after graduation. A failure to serve the full two years in a directed post will result in the student having to repay the government the cost of the training in full. Bonded students will be placed within either PNFPs or public institutions according to MoH priorities. This bonding arrangement is currently reliant on donor funding.

### TEACHING HOSPITALS AND RESEARCH INSTITUTIONS

There are multiple organizations conducting research in Uganda, including universities and other public and private institutions. Mulago Hospital, the national referral hospital, is the nation's main teaching hospital and is attached to Makerere University. While there is a significant amount of medical research in Uganda, much in partnership with international institutions, the country lacks a coordinated research agenda. While some areas are "over-researched" and supported by funding reflecting international priorities, other areas are under-funded. A bill has recently been passed to empower the Uganda National Research Organization to manage the research agenda and assure that research informs policy. If managed correctly, a coordinated research agenda will ensure that research reflects medical priorities as opposed to the political directives of a select few.

There is limited research on traditional and complementary medicine and areas that are unrelated to communicable disease. While the Natural Chemotherapeutic Research Lab was created as a research institution, staff members spend the majority of their time engaged in clinical work with patients. As a result, there is very little research done in the area of traditional and complementary medicine, which is frequently accessed by the Ugandan population.

## IN-SERVICE TRAINING

In-service training, which includes continuing professional development for staff once they are in their jobs, is inconsistently provided and largely determined by the facility. When training does occur, there appears to be a bias toward selection of participants from the central regions and large hospitals, which disadvantages those health workers in rural or smaller facilities.

### MoH-SUPPORTED TRAINING

The Human Resources Development Division (HRDD) within the MoH is responsible for the development of the country's health human resources, including in-service training, defined as post-graduate and short training courses. The HRDD considers the needs of both the public sector and PNFPs, but does not account for PFPs.

The MoH's in-service training center was responsible for all training development that was then dispersed to districts and regional hospitals. However, partially due to the confusion surrounding the placement of medical training institutions with the MoES, the in-service training center has declined, resulting in a shortage of in-service health training. Most training is now delivered through vertical programs, such as HIV/AIDS or malaria, with little innovation in the area of training more broadly. In response, HHRD has tried to support training assessments in the districts in order to develop training plans. Efforts include building the capacity of district health teams to prioritize and sequence training courses for staff.

The effects of insufficient training from the MoH are felt within the private sector as well, as many public servants moonlight in private clinics. These individuals whose training plans have leveled off are no longer receiving the training that helps assure quality within the private sector as well. There exists an opportunity

to revive the in-service training capability, beginning with key courses such as leadership and management. E-learning can also be increased, leveraging the recent success of Uganda's Infocom in bringing broadband Internet access to the country.

### REINFORCING CONTINUING PROFESSIONAL DEVELOPMENT

*USAID's Capacity Project* has been working with Heath Workforce Advisory Board and the relevant associations and professional councils to add rigor around continuing professional development (CPD) through the development of in-service training standards. The councils intend to form a body that will accredit training partners. Standards and guides have been developed and CPD training will be delivered through associations and district and regional hospitals. Centers of excellence will be identified for different areas. For example, the Infectious Disease Institute at Mulago will be the center of excellence for HIV/AIDS. This will impact licensing renewal, where applicants are required to have a certain number of CPD credits, which the councils will begin to enforce.

## MEDICAL FACILITIES

### PUBLIC FACILITIES

Accountability in public health facilities is often low and management is weak, resulting from the placement of clinical professionals into management positions without sufficient relevant management training. The resulting lack of oversight and support supervision has created a "flexible" working environment, characterized by high levels of absenteeism. Operating in a system without accountability, some health workers spend more time in their private practice or elsewhere than at their public sector job.

### PNFPs

The PNFPs, coordinated by the three religious medical bureaus, tend to benefit from strong internal organizational systems but suffer from unstable funding levels due to reducing resources. Recently, PNFPs have also increasingly been the victim of internal brain drain as staff members have started moving to the public sector following a wage increase for government health workers. PNFPs have also traditionally lost staff to private sector facilities. As a result, they are especially struggling to reach districts. However, while PNFPs have difficulty offering salaries that are competitive with the NGO sector and in some instances the public sector, they tend to attract staff with non-monetary benefits such as training opportunities, free medical care, and free housing. These benefits are particularly meaningful in hard-to-reach places where staff members are reluctant to remain. Ongoing training and professional development is an aspect of PNPFs that health workers find attractive.

Employment conditions also tend to vary across PNFPs as no uniform standards are enforced across the sector. However, management practices tend to be better generally in PNPFs largely because of a decision to align core competencies of the staff. While a public facility will often place a medical doctor in charge of administration, in PNFPs a medical doctor will run the clinical practice, while a trained management professional will oversee the organizational component.

### PFPs

While private for-profit facilities are perceived to have the best management, there is also a perception that the health workers tend to be young and inexperienced. Although consumers recognize this to be the case in some instances, the positive attitude and bedside manner of these medical professionals is what attracts most patients to them. Those who can afford to pay will therefore prioritize the relatively well-managed private health facility in order to have a more pleasant and efficient experience.

Lack of access to financing is the biggest issue preventing doctors from setting up a private practice. Minimal availability of start-up capital often places limitations on the quality and size

of the practice and the ability to scale up and form networks. A relatively bureaucratic business environment may also encourage health workers into the informal sector. This issue is further addressed in the Access to Credit section of the report.

# SUPPORTING INSTITUTIONS

## MEDICAL ASSOCIATIONS

There are a plethora of medical associations in Uganda, though membership is voluntary and not required for professional licensing. In theory, membership includes benefits such as training, professional development, advocacy, and professional networking opportunities. Some professionals achieve continuing professional development (CPD) credit through their respective associations, though the impetus to do so has been limited due to the lack of rigor in enforcing CPD requirements for relicensing.

In reality, associations have varying levels of effectiveness and are not yet playing their full role within the health system. The five umbrella associations include: Uganda Medical Association, Uganda Pharmaceutical Society, Uganda Dental Association, Uganda National Association of Nurses and Midwives, and Uganda Association of Allied Health Professionals. Traditional healers are organized under the Uganda Traditional Healers Association, though membership is small.

Some associations, such as the Uganda Private Medical Practitioners Association (UPMPA) are actively engaged in working groups at the MoH. The vision of the UPMPA is to form one umbrella association for all private health practitioners to focus on quality assurance and self-regulation within the industry, though at present a unified private health self-regulating organization is still merely a vision. Such an umbrella association of private health practitioners would enhance the level of sophistication of the private health sector, particularly if the association enforced international quality standards for its members. Membership in this type of association would also signal quality to consumers, giving them a gauge by which to select private practitioners.

**KEY SUPPORTING INSTITUTIONS**

- Medical Associations
- Ministry of Gender, Labor, and Social Development
- Donors

## MINISTRY OF GENDER, LABOR, AND SOCIAL DEVELOPMENT

The Ministry of Gender, Labor, and Social Development is collaborating with the MoH on a UNFPA-funded training program to ensure youth-friendly health service delivery. Responding to a teen pregnancy rate of 24.6 percent, as well as claims of ill treatment of young patients by medical personnel, the program aims to train health professionals (from both the public and private sectors), ensuring appropriate treatment of young patients as well as privacy within the facility. The program has been active in a few districts and is under review.

The Ministry of Gender, Labor, and Social Development also developed the National Policy on HIV/AIDS and the World of Work, which has eased the burden on HIV/AIDS-positive individuals, as well as medical professionals. USAID's Capacity Project is also working to develop a workplace safety policy to protect health workers against HIV/AIDS. The policy is based on ILO standards.

## DONORS

Donors have also played a critical role in the training and development of health workers in Uganda, including the financing of training programs. However, as mentioned in the Crosscutting Themes section, while donors have played a critical role in health service delivery in Uganda, there are also indications that they have unintentionally distorted the labor market and contributed to internal "brain drain" of medical personnel from clinical settings to

public health programs. Attracted by high salaries, many health workers abandon clinical work in order to work for donors and NGOs.

In the case of the Makerere School of Public Health, which was established to develop public health professionals primarily for service in the districts, approximately 60 percent of graduates join NGOs, while 40 percent accept jobs within the districts. In fairness, this phenomenon is not solely because of more attractive salaries offered by donors, but also because of the inability of districts to successfully absorb new staff. Even so, the net effect is that clinical professionals are being pulled away from clinical practice and are often engaged in public health jobs, which may not require a clinical background.

# SOCIAL DYNAMICS

## CHOOSING A MEDICAL CAREER

Students interested in studying medicine take the Uganda Advanced Certification Exam, which determines if they will be accepted to medical school; admission is largely merit-based. However, disadvantaged districts without strong schools and teachers very rarely see students take and pass the exam and are therefore under-represented in the medical schools. These are some of the same districts that then lack sufficient medical personnel. While both men and women pursue medical careers, the majority of nurses and midwives are women, while men make up the majority of medical doctors and allied health practitioners.[53]

## WORKING IN THE PUBLIC HEALTH SECTOR

Public health workers are often discouraged by poor working conditions, low pay, and a heavy workload. In addition, a lack of a career path for many contributes to low morale and high attrition. Medical personnel complain of continuous stress resulting from overwork and poor working conditions. Absenteeism in the public health sector is a large problem due to lack of managerial oversight and a tendency for health workers to prioritize their private sector employment over their public sector positions. 40 percent of health workers are consistently not present at work, representing an annual loss of approximately 29.4 billion shillings.[54] However, there is still an appeal to working in the public sector where medical practitioners may find access to training and innovation as well as the security of a reliable salary. In some instances, health workers' affiliation to public sector institutions also enhances their reputation and may reinforce their private practice.

## WORKING IN THE PRIVATE SECTOR

As previously mentioned, many health workers employed in the public sector also work in the private sector, at either large PFPs or in private practice. They are attracted by the prospect of profit as well as better working conditions and a work load which is less crushing than in the public sector. With an awareness that patients are paying for service, it is said that the same medical professionals adopt a more pleasant bedside manner when seeing patients in a private clinic. While this dual practice, and effective dual service, occurs frequently between the public and PFP sector, many PNFPs prohibit staff from holding a second job. While PNFP salaries may not be the most competitive, they tend to offer additional benefits such as lodging, training, and good working conditions, which many health workers find attractive. In addition, many health workers are attracted to PNFPs which are affiliated with their faith.

## MEDICAL "BRAIN DRAIN"

Uganda experiences both internal and external brain drain. Within the country, health workers are often attracted to higher-paying jobs with the donor and NGO sector. Local governments also lose health workers to the central districts, and rural communities have lost employees to the urban municipalities as the workforce has shown a strong preference for urban posts. Many also gravitate toward those subject areas where there has been significant funding,

53 *Human Resources for Health Policy, April 2006.*

54 *The Uganda Human Resources for Health Strategic Plan 2005–2020; Supplement 2009: A Health Workforce Crisis in Uganda: Time for Real Action.*

e.g., TB, malaria, and AIDS, and neglect other important health topics.

A significant number of health workers also seek positions outside of the country, looking to the United States, the United Kingdom, Canada, South Africa, and East Africa as countries that could offer a better salary and working conditions. Salaries in Uganda are low in comparison to its neighbors. Health facilities in Rwanda, for example, can offer payment five times the salaries in Uganda. Makerere Medical School sees approximately 20 percent of its graduates leave Uganda for better pay and working conditions, 50 percent remain to work in Kampala, and 30 percent move up country to local district hospitals, regional hospitals, or PFPFs. Many who choose to go up country are often returning to their home districts.

## ACCESSING HEALTH CARE

In theory, all Ugandans have free access to health care at public medical facilities. User fees at government facilities were abolished in 2001, purportedly to expand the equitable distribution of services to all. In reality, patients are often asked to pay for services in public facilities, a phenomenon that has been recognized by the MoH. The *Uganda Human Resources for Health Strategic Plan (2005–2020)* points to "poor ethical behavior; e.g. asking for bribes, abusing women" as obstacles to effective health care delivery. Debate continues regarding the value of "free" health care, which often results in hidden costs for the consumer. Formal user fees, even if nominal, would make more funds available for administrative and medical expenses and help moderate the workload. At present, in addition to bribes for service, in many instances, patients must provide basic equipment such as rubber gloves or sheets, as public facilities often run low on supplies.

Negative attitudes from health workers may be a contributing factor in discouraging patients from attending health clinics. Patients have also reported gender and age discrimination. In some instances, young people report being treated with disrespect, particularly when they are seeking contraceptives. Notably, the Ministry of Labor initiated a program to address this discrepancy and ensure that young people are treated respectfully. Women are also reportedly treated differently and may be turned away due to an inability to pay. Additionally, while the attitude toward HIV/AIDS has improved following a targeted campaign from the government and NGOs, discrimination still exists, with some HIV/AIDS patients mistreated at the point-of-service.

Because of hidden costs at public sector facilities, the poor attitude of overworked health professionals, and the often lengthy wait for service, those who can afford private health care avoid public facilities altogether. The wealthiest Ugandans leave the country for any significant medical procedure, traveling to Kenya or South Africa or in some instances to Europe.

While patients informally recount mistreatment within the health care system, there is no enforcement of standards and no place for consumers to formally lodge their complaints. Several consumer protection organizations have formed to address these issues and a charter enumerating the Rights of the Patient has been accepted by the MoH.

## TRADITIONAL AND COMPLEMENTARY MEDICINE (TCM)

An estimated 60 percent of Ugandans attend traditional healers as their first point of contact in their primary health care.[55] Only 40 percent of newborn deliveries occur in a health facility, with the majority of women choosing to stay home with traditional birth attendants.[56] Despite this reliance on traditional healers, there has been little success in regulating the sector or connecting traditional and allopathic practitioners.

The strong reliance on traditional medicine is due to a number of variables, including the cost required to travel to a formal health clinic, reported mistreatment by over-worked

55 Draft National Policy on Public Private Partnership in Health.
56 *Annual Health Sector Performance Report Financial Year 2007/2008.*

medical professionals, fees at private clinics, and flexible payment schedules of traditional healers. Traditional healers also are much more available than allopathic practitioners, with one traditional healer for between every 200 and 400 people. This contrasts with the availability of allopathic practitioners, where there is an estimated one practitioner for every 20,000 people.[57]

Although the majority of Ugandans use traditional healers, the TCM sector is unregulated, without a legal and regulatory framework to ensure quality care by qualified practitioners. The TCM sector is particularly challenging to regulate; practitioners are dispersed and rarely organized into professional groups, and the variations in traditional medicine therapies are difficult to define and regulate.

There is no code of ethics, licensing body, or regulations for TCM practitioners. While a TCM policy has been drafted (though not yet approved), there is a weak regulatory infrastructure to support the sector and few resources allocated toward TCM research and development. This has contributed to limited public awareness about both the potential benefits and risks of TCM.

Uganda has publicly committed to leveraging the benefits of TCM and has signed a number of national and international commitments to this end. Despite the work of the National Chemotherapeutic Research Center, a government entity based at Mulago Hospital that integrates traditional and conventional medicine, TCM is not formally integrated into the health care system. While the government has tried to coordinate with the TCM sector, the level of organization within the sector is low, leaving no viable partner with which the government could engage. Most recently, the government established a TCM national task force, which developed a draft policy on traditional and complementary medicine as a component of the public-private partnership for draft health policy. The policy has not been formalized.

57 Id.


# ACCESSING FINANCE

Access to an adequate selection of financial services is necessary to meet the demands of the health sector so it may operate at peak performance. Financial products can enable health sector practitioners to acquire land, construct and improve facilities, expand services and business development, as well as provide for operating expenses as the need arises. At this time the private health sector remains starved for capital, stunting the growth of the private sector in the health system. Pools of capital in Uganda remain shallow, and rural financing, especially for health care activities, is extremely thin.

In Uganda, an estimated 67 percent of the private sector finances their activities exclusively through reinvestment of retained earnings. Accurate data regarding the private health sector's access to finance is nonexistent, but it is informally estimated that nearly 90 percent of private health service providers finance their start-up, operations and capital investments through retained earnings. Private not-for-profit health service providers often have access to donations from foreign donor organizations, as well as access to public sector grants, but private for-profit health service providers finance almost exclusively through retained earnings.

Throughout this assessment, a recurring theme expressed by private sector health service providers and lenders alike was health providers' low level of business acumen. Health sector businesspersons often have no training in basic business skills or financial literacy, and thus are not always cognizant of available financing options. Further, basic business planning and sound accounting practices are cited as key limitations on financing availability.

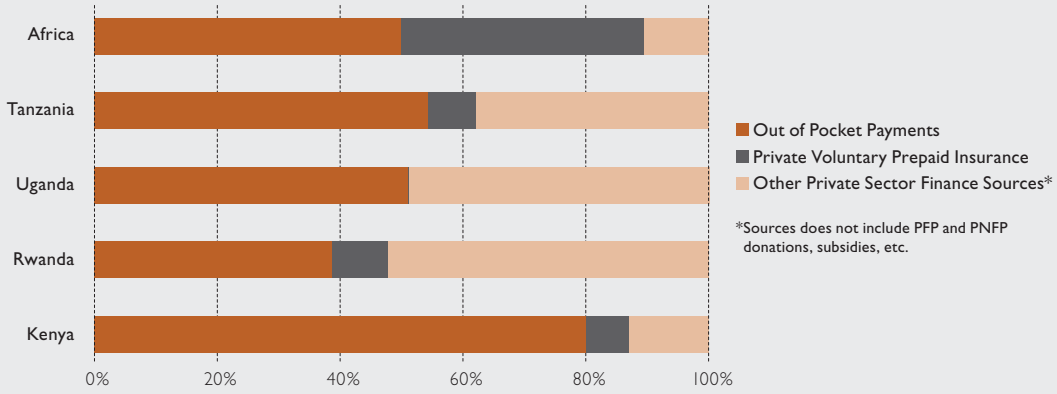
Additionally, the issue of credit risk is significant. Credit history reporting exists in Uganda, but is still developing, with insufficient data to establish robust user histories. Rather than seek out new customers, many financial institutions focus on cross-selling services with existing customers to mitigate new consumer risk.

While Uganda is endowed with lush vegetation, an enviable climate, natural beauty, and extractable resources, there are nevertheless limited resources available for health consumption. Total expenditure on health in Uganda in 2006 was 7.6 percent of GDP, approximately $71 per capita. To boost consumer financing of health services, risk-pooling products such as community health insurance plans, health maintenance organization insurance programs (HMOs), and private insurance plans are also available to health consumers, though presently only four percent of the population maintains non-life insurance policies. The actual percentage for health insurance, a subset of non-life insurance, is likely much lower, although regulators do not separately report on the health insurance market.[58] Private insurance schemes are driven mainly by microinsurance and employer-funded health programs (either insurance or direct access to workplace clinics). Only two companies are listed as providers of medical insurance in Uganda, and only five HMOs exist.

Uganda does not have universal health insurance coverage. Though the Ministry of Health pushed forward a plan, Parliament did not pass the National Social Health Insurance Scheme in 2008, bowing to pressures from employer groups, trade unions, and worker groups. Supporters of the National Social Health Insurance Scheme continue to advocate on behalf of the scheme, which if passed could

58 According to the World Health Organization's World Health Statistics 2009, as of 2006 only 0.2% of private outlays for health services are financed via private voluntary health insurance schemes. Available at http://www.who.int/whosis/en/.

**PERCENTAGE OF SOURCES OF PRIVATE FINANCE**




Source: World Health Organization World Health Statistics 2009

significantly increase the cost of doing business for formal business organizations, as well as affect the private health insurance industry.

Rural access to finance is extremely limited, exacerbating burdens for rural private sector health service providers. Higher operating costs, added risk, and smaller markets limit the scope and scale of financial services. Further, lower average incomes and smaller markets limit access to health consumer financial products such as private insurance schemes. Private not-for-profit community health insurance schemes have been established since the late 1990s in some villages in central and western Uganda, but few new community health insurance schemes have started since 2005, and total participation hovers around approximately 30,000.

An assessment of the laws and institutions of the business enabling environment in Uganda was conducted by USAID in 2008, with a thorough review of the laws, policies, and institutions that impact the ability of the private sector to generally access credit, investments, and other financing mechanisms. Rather than re-create this information, this chapter will instead provide a general overview and then focus on specific hurdles faced by the private health sector and identify potential solutions within this specific sector.

## LEGAL FRAMEWORK

The legal framework for accessing finance in Uganda is largely sound, though certain targeted reforms could help facilitate better access to finance for the private sector broadly, and the private health sector specifically. If implemented, the 5-Year Markets Development Plan 2008–2012 will bring Uganda up to international best standards for regulation of the financial system. Focused efforts on this plan should result in significant improvements to the enabling environment for finance across the private sector, including the private health sector.

### CREDIT AND CAPITAL

The Bank of Uganda Act, 1993, as well as the 1966 Constitution, as amended, Article 162(2), establish the mandate for the Bank of Uganda (BoU) to regulate financial institutions and promote currency stability. The Bank of Uganda is viewed favorably, promoting forward-looking practices and sound competition. In 2007, the Bank of Uganda opened up licensing requirements, encouraging four new banks to enter the market and one bank to convert from an exclusive mortgage practice to become a full commercial bank. However, some gaping holes in the Bank of Uganda Act should be filled as the financial sector continues to grow.

Under current laws, the Bank of Uganda does not regulate microfinance institutions (MFIs) or

Savings and Credit Cooperative Organizations (SACCOs). Currently, MFIs remain unregulated by the BoU. However, microfinance deposit-taking institutions (MDIs) are regulated by the BoU under the Micro Finance Deposit Taking Institutions Act, 2003, establishing capitalization requirements and creating an MDI deposit guarantee fund. The BoU's regulatory role covering banks is defined in the Financial Institutions Statute, 2003.

The Bank of Uganda is taking steps to expand financial system architecture beyond brick and mortar financial institutions through the promulgation of new rules on electronic and mobile commerce. Telecommunications companies, in partnership with commercial banks, are now beginning to offer short message service (SMS) financial transfer and mobile banking services. Coupled with effective evidentiary rules for e-commerce and a proposed public education program to sensitize Ugandans to e-commerce, mobile banking could prove to be an excellent resource in Uganda to offer services to previously inaccessible rural regions.

## MOVABLE PROPERTY

The Chattels Transfer Act lays out the rules to establish a security interest in movable property. While some gaps exist, the Chattels Transfer Act provides a workable system for movable property. Beyond leasing, discussed at greater length below, the private health sector is unable to tap the capital stored in their movable medical property, according to lenders, because lenders are unable to properly value medical movable property. No established medical aftermarkets exist for resale of used medical machines, and financial institutions otherwise do not want the reputational risk exposure for recovering a medical asset.

## LEASING

In the health sector, where sophisticated medical equipment can take years to self-finance, leasing presents an opportunity to acquire new, necessary equipment sooner. Uganda has no law on leasing, though a draft law has been under discussion for years.

Confusion exists as to the nature of a leasing relationship, especially in financial institutions that do not currently offer leasing products. A standard leasing transaction exists between three parties; a seller of a product, a financial institution that purchases the product, and a lessee, the individual or company that uses the product for an established, periodic fee. Lease arrangements can exist either for movable or immovable property. Leases typically exist as a capital lease, where ownership transfers with payments on the lease or as an operating lease, where the lessor retains ownership and the lessee merely pays a fee to use the property. Virtually all leasing in Uganda is via capital leases.

An advantage of a lease, as opposed to a loan secured by collateral, is that the owner/lessor retains ownership of the property, and thus has a stronger claim in recapturing the property if the lessee breaches their lease. Presently, two commercial banks have developed extensive leasing departments, although it still only remains as approximately two percent of the market. For the most part, leasing offered through commercial banks is targeted at high-volume transactions among very large

companies, and is still mostly a product tailored for a niche market.

While no law regulates lease products, confusion exists as to whether MFIs may offer leasing products. Most MFIs do not believe they are authorized to offer leasing, as it falls outside of the scope of a two-year microloan. Some MFIs advertise "microleasing" products, but these arrangements are more a modified microloan coupled with an agency agreement whereby the financial institution acts as a purchasing agent on behalf of the borrower. Ownership does not remain with the MFI, but rather passes at the time of purchase, and thus would not qualify as a lease agreement. Through this assessment, no true leasing products appeared to be offered by MFIs.

Some medical equipment leasing companies do exist, offering standard five-year lease repayment terms, but there is little competition, so prices remain prohibitive for many private health service providers. Additionally, due to limited experience with leasing products, many private health providers do not understand or trust lease transactions.

The absence of a law on leasing in the corpus of Uganda's commercial laws is evident. Confusion has a chilling effect on wider use or a diversity of leasing products. A draft leasing law should clearly define leasing transactions, provide clear distinctions between capital and operating leases, and clarify the types of institutions that may engage in leasing. Additionally, confusion exists as to who may depreciate the leased asset. The government of Uganda should make enacting a leasing law a priority.

## FRANCHISING

Franchising has been a useful alternative to extensive financing when scaling up distribution and service delivery, including in the for-profit and not-for-profit health industry. Franchising has been particularly effective when quality assurance is critical. Under a standard franchise arrangement, a successful company with a proven concept, management, and operations will, for a structured fee, authorize another person to do business under the company's brand, applying its methods and its same quality standards. Franchisors maintain sufficient controls to ensure brand compliance, standardization, and a minimum quality level, but operations are handled by the franchisee. Since each franchisee will typically fund some, if not all of its franchise, the franchisor can quickly scale up the brand's market presence at significantly reduced costs.

Franchise arrangements tend to be lower risk than other new business ventures, since franchisors can already point to successful application of a proven concept; thus, financing tends to be more readily available at lower rates for franchises. Further, as franchises scale up, economies of scale tend to help reduce marginal production costs. Franchises have proven effective in scaling up health product and service distribution in Kenya, as well as a not-for-profit maternal health clinic system in Bangladesh and a public/private partnership distributing drugs in the Philippines.

Uganda does not have a law on franchising, but franchise-style arrangements do exist, in limited instances. An effective franchising regime rests upon a secure foundation of intellectual property rights. First and foremost, the franchisor must be able to protect its branding from charlatans who would tarnish or dilute the brand of the franchise. Strict quality assurance programs, along with management and operations and supply chain management, tend to foster successful franchises. While a law is not necessary in the immediate term, it would help in the longer term.

## PRIVATE HEALTH INSURANCE

Insurance and reinsurance companies, brokers, assessors, adjusters, and risk inspectors are regulated according to the Insurance Act, 1996, and The Insurance Regulations, 2002. Insurance companies and professionals must secure a license before practicing their profession, and must renew their license annually.

**KEY LAWS**

- Bank of Uganda Act
- Insurance Act
- Chattels Transfer Act
- Financial Institutions Statute
- Microfinance Deposit-taking Institutions Act of 2003
- National Health Insurance Scheme (draft)

The Insurance Act requires total paid-up capital of 200 million shillings for a domestically owned life or non-life insurance company. Foreign-operated non-life and life insurance companies require total paid-up capital of 1 billion shillings, and foreign-operated reinsurance companies must have paid-up capital of at least 2.5 billion shillings. Annually, five percent of profits must be used to build up the company's capital base. Furthermore, insurance companies must maintain a security deposit at the Bank of Uganda equal to 10 percent of the paid-up capital of the company. This deposit is established to support the company during a substantial loss, and is also used in the event of a wind-up or dissolution of business to discharge liabilities on existing policies that remain undischarged at the time of winding up. The capitalization requirements, along with reserves policies for Ugandan health insurance providers, reduce likelihood of insolvency, though the capitalization requirements could serve as a barrier to formal micro-insurance schemes.

Although the Insurance Act purportedly provides broad authorization for the Uganda Insurance Corporation to regulate the entire insurance industry, **health maintenance organizations** (HMOs) in Uganda remain unclassified and unregulated under the existing legal framework and, therefore, data on this market is not adequately captured by the government. No special licensing procedures, capitalization requirements, or regulations on reserve methodologies exist for health service providers that provide HMO insurance offerings. While a minimal level of regulation should be established to mitigate against insolvency and ensure adequate reserve policies are in place, standardized accounting practices across the profession are maintained, and basic corporate governance standards are met, regulators should limit regulation in this area to enable innovations in this new market segment.

Another issue impacting the distribution of insurance products, particularly to rural communities, is a lack of distribution networks to effectively reach a widely dispersed population. The Insurance Act does not allow MFIs or telephone companies, sectors with the deepest network penetration into rural regions, to offer insurance or micro-insurance products. Regulations should be developed to authorize partnerships between insurance companies and phone operators to leverage existing rural finance infrastructure for the efficient expansion of the pool for insurance policies.

## NATIONAL SOCIAL HEALTH INSURANCE SCHEME

Uganda presently has no national social health insurance scheme. Access to the public health system is free, financed at the national, regional, and local levels, and subsidized by "private sector" wings where patients can pay for upgraded facilities and services. User fees for public health institutions were abolished in 2001, although user fees for private sector institutions and private wings within public hospitals are an estimated 54 percent of total expenditures on health care in Uganda.[59]

In spite of the free public health system, the Ministry of Health has pressed for a national social health insurance program that redistributes health financing to subsidize access to fee-based services. Those in the private sector, and specifically individuals interviewed as a part of this assessment, voiced concerns that the mandatory nature of the national social health insurance scheme would impact their own private insurance schemes provided by their employer; and especially voiced concerns over the mandatory nature of the capitation

59 As discussed in more detail in the Governing the System chapter, the accuracy of this number is in question, though participants in this assessment, public and private, generally agreed that the actual utilization of private health sector services was likely around 60 percent of expenditures.

fees that would be required from formal sector employees. Many rightly viewed the capitation fees as a tax for a service. This is especially troublesome as they do not want or need the service, and it would only serve as yet another cost of doing business.

Employers associations and workers associations combined efforts to lobby against the public health insurance scheme in 2008. Formal employers noted that the rollout of a nationwide public health insurance scheme would create incentives against formalizing a business in the private sector. Interviewees for this diagnostic noted that the National Health Insurance Scheme, as originally designed, would amount to a subsidy that would benefit the informal sector, at the expense of formal companies. As designed, the National Health Insurance Scheme was to be funded by an 8 percent income tax on formal employees; with employees responsible for 4 percent, and their employers responsible for the other 4 percent contribution. With a formal workforce representing only approximately 3.5 percent of Uganda's population, this mandatory income tax would have had a chilling effect on the government's efforts to promote business formalization in Uganda.

In 2008, the Parliament voted down a draft bill establishing a national health insurance scheme. However, proponents continue to voice support for a system in the media. The Ministry of Health is embarking upon a "sensitization" program to attempt to promote a public health insurance system, although there seems to be little support for this initiative in the private sector.

# IMPLEMENTING INSTITUTIONS

## BANK OF UGANDA

The Bank of Uganda serves as the country's central bank, an autonomous government agency regulating the system to promote price stability and a healthy financial sector. In addition to establishing monetary policy through diverse instruments, the BoU also regulates financial institutions throughout Uganda. The board of directors of the bank is nominated by the president, and if approved by Parliament, is seated for five-year, renewable terms. The BoU commands a deal of respect among lenders and the private sector in Uganda, and is considered a force for positive reform of the business-enabling environment.

In response to a strengthened shilling, and in the face of heavy criticism from the private sector, the BoU dropped its marginal lending interest rate (i.e., the rate at which the BoU lends to commercial banks in Uganda) by 3.4 percentage points in March 2009; as of July 2009, the bank rate was set at 10.8 percent. As of May 2009, only two commercial banks had dropped their prime lending rates, to 16 percent and 15 percent. The remainder of the commercial banks' prime interest rates continues to hover around 20 percent, with the highest around 24 percent, which is cost prohibitive for much of the private health sector.

The BoU regulates only a portion of the institutions in the financial sector. The BoU regulates commercial banks, credit institutions, and microfinance deposit-taking institutions. The BoU does not regulate non-deposit-taking MFIs or SACCOs.

## CREDIT REFERENCE BUREAU (CRB)

According to several financial institutions, one of the key drivers for the high cost of capital in Uganda is the premium required due to a lack of credit history in determining an adequate risk profile for private health sector companies. Accurate credit history maintenance benefits banks, as they can ascertain potential credit risks based upon prior actions by the borrower. Credit histories can also improve loan repayment rates because borrowers know their actions will have a future impact on their personal cost of capital.

The CRB in Uganda is housed in the Bank of Uganda and managed by a private sector firm

**CREDIT HISTORY: A (NOW) UNFUNDED MANDATE**

Participation in the Credit Reference Bureau (CRB) is mandated for all Tier 1, Tier 2, and Tier 3 financial institutions regulated by the Bank of Uganda. In the rollout phase, donors have subsidized the first unit purchased by each branch. However, while participation in the CRB is mandatory for all commercial banks, credit banks, and microfinance deposit-taking institutions, traditional non-deposit-taking microfinance institutions are not authorized to participate.

Absent any subsidy to support participation, MFIs seeking to graduate to MDI status now factor in the following fees as a cost of graduation:

$1,500 per unit – fee to purchase system hardware;
$5 per card – fee owed per card to set up card in system
$100 per branch – monthly management fee

under a five-year contract. The Credit Reference Bureau has been collecting records since April 2008 and will retroactively track data from 2007 as sufficient information is compiled.

The process for CRB loan card distribution is demand-driven. Prospective borrowers must complete a CRB application via their bank's loan officer as a precondition to loan application. Borrowers must then submit five types of identification, and submit to a 10-fingerprint scan. If approved for the card, the borrower will receive a loan card encrypted with biometric data that can be used by a loan officer at any regulated financial institution to identify the user's data.

The CRB, through the BoU and with support from the German government, has begun a public awareness campaign to improve public understanding of both the need for improved credit history information and the role and processes of the CRB to address the need.

There are no plans to expand the scope of the CRB beyond loans in Tier 1, 2, and 3 financial institutions. The credit score information will only be accessible to financial institutions participating in the CRB, and thus the extensive MFI network throughout the country will not serve as data sources and will not benefit from access to credit history information. This weakness is appreciable because it keeps MFIs from accessing information that can marginally reduce the costs of lending associated with risk. Additionally, microcredit borrowers cannot use consistent, on-time payments of microloans to build up their credit history for future loan applications.

## FINANCIAL INSTITUTIONS

There are at present 16 licensed commercial banks in Uganda, which offer extensive loan products, including trade financing, mortgages, large-scale commercial loans, student loans, deposit accounts, timed deposit accounts, and current accounts, among other services. Most commercial banks have never offered a loan product to the health sector, and two commercial banks suggested that the health sector presents certain unique risks that do not comply with their risk guidelines.[60] Notable exceptions have been made for health service providers and pharmacies whose owners have a long personal customer relationship with the institutions, but for the most part, PFP service providers and pharmacies are excluded from accessing finance via traditional commercial banks. The recent deregulation that opened up competition from new entrants into the commercial banking space will likely improve access to finance, as new market entrants look for new customer bases. However, for now, access to financing through commercial bank loans remains largely unavailable to the private health sector.

In addition to commercial banks, there are currently four MDIs, and thousands of MFIs and SACCOs that offer loans at approximately 200,000 shillings on average, for typically a

60 When pressed, the interviewees suggested three specific risks related to private sector health institutions: 1) the market for these services is too new and too many uncertainties exist in the quality of the businesses due to lax regulatory oversight, and insufficient bank staff understand the unique demands of the industry; 2) likelihood that bank would not be able to execute warrants to confiscate the collateral, fixed or movable, for fear of media backlash; and 3) lack of business sophistication in the organization and management of mostly small clinics.

6-month term, up to and almost always less than two years. MFIs have begun offering bridge loans to purchase inventory, and also for bridge loans while awaiting reimbursement of insurance claims, though this practice still remains rare.

## CAPITAL MARKETS AUTHORITY AND UGANDA STOCK EXCHANGE

The Capital Markets Authority (CMA) serves as the primary body responsible for regulating capital markets, promoting their development, and expanding their utilization. The CMA is the licensing body for broker/dealers and investment advisors as well as financial reporters who provide financial advice columns in Uganda. The CMA serves as the representative for EAC securities harmonization, and also supports legal reform programs to update the legal framework for capital markets management. The CMA approved of the Uganda Stock Exchange as the exclusive stock exchange in the country. The Uganda Stock Exchange and the CMA are both staffed with well-educated employees and managers who are cognizant of best practices in capital markets management. Despite best efforts, only two corporate bonds have been listed, and neither of these were health bonds. Further, while the national government has listed 12-year bonds, no municipal bonds have been listed, though the laws of Uganda allow districts to raise capital. According to the CMA, it had not thought to target private health sector institutions, especially private sector hospitals, for incentives to list on the stock exchange, but is interested in pursuing this. The CMA is also interested in identifying possible candidates for municipal health bonds, to be listed with the intention of financing capital improvements at public hospitals. The CMA has waived certain disclosure requirements for listed companies in an effort to encourage greater participation in the capital markets, but shares still remain relatively illiquid, with very low volume traded, so additional incentives will be necessary.

## INSURANCE REGULATORS

The Uganda Insurance Commission (UIC), housed as an auxiliary institution under the Ministry of Finance Planning and Economic Development, was defined, established, and given its legal mandate through the Insurance Act, 1996. The commission bears the primary responsibility for establishing codes of conduct for the insurance business, licensing insurance companies, brokers, and other professionals involved in the insurance business; for protecting beneficiaries in insurance contracts; and for handling official complaints from members of the public regarding insurance companies. Three out of eight seats on the Uganda Insurance Commission are reserved for members of the insurance profession, two of which are reserved for representatives from the Uganda Insurers Association, one seat of which is reserved for the Uganda Association of Insurance Brokers. While industry participation in policy development and regulation is welcomed, concerns have been raised about the potential for abuse in granting seats to members of the insurance industry.[61]

## PRIVATE HEALTH INSURANCE COMPANIES

Only two private health insurance companies are licensed with the Uganda Insurance Commission to provide medical insurance, and a third and largest health insurance company was involved in a licensing dispute with the Uganda Insurance Commission. The UIC does not separately track health insurance, lumping health insurance into a non-life miscellaneous category, so accurate information about health insurance data is difficult to ascertain. However, the aggregated non-life insurance policies totaled 402,180 as of March 2009, or approximately 1.2 percent of the population. Thus, the total market penetration for health insurance is likely quite lower.

Key drivers for the low market penetration rates for insurance in Uganda, according to the UIC, include a lack of awareness of the benefits of insurance, high levels of poverty, and a lack of products geared toward Ugandans living in rural communities.

61 "Competitors plot to windup Microcare," *Weekly Observer*, April 27, 2009.

## REINSURANCE

Reinsurance is a necessary component to sustainable insurance providers. Reinsurance mitigates against catastrophic risk by any one insurance provider by spreading the risk across all plans covered by the reinsurer. There is no reinsurance provider in Uganda, and little progress has occurred since 2006 in the development of a national reinsurance company. Regulated private insurance providers are required to procure reinsurance protection from rated agencies abroad. However, informal insurance providers that exist outside of the formal insurance regulatory framework are not obligated to pursue reinsurance, though many of the HMOs (see below) that presently remain unregulated do pursue reinsurance.

## HEALTH MAINTENANCE ORGANIZATIONS

At least five formal, registered health maintenance organizations (HMOs) exist in Uganda. However, HMOs exist outside of formal insurance regulatory framework; the UIC provides no regulatory oversight of HMOs. HMOs in Uganda are typically prepaid plans that are closely integrated with a single, or a very limited number of health service provider organizations, mitigating problems such as provider claims payments and administrative burdens of fee disputes. Limited regulatory oversight by the UIC for capitalization, reserves, plan organization, auditing and accounting standards, and reporting requirements should be enacted to protect consumers from plan insolvency. However, these regulations should be specific and limited in scope to enable HMOs to continue to develop their products to meet the needs of consumers cost effectively, without an excessive regulatory burden.

## COMMUNITY HEALTH FINANCING PLANS

Community health financing plans (CHFs) are non-governmental arrangements, typically associated with specific communities, to pool risk among community members. In Uganda, most CHFs are facility-based, rather than community-based, and are often owned and managed by the private health facility sponsoring the plan.[62] CHFs exist unregulated by the UIC, and are often confused with HMOs.

Further, there is no single registration body for CHF plans, and no legal formation standards. In a survey of CHFs in Uganda, entities' self-reported legal formation structures including registration with the business registry as a company, registering as a community-based organization at the district, to remaining an unregistered, informal association between private sector cooperatives and a medical facility.

CHFs have few, if any, accounting standards or procedures, and often no access to training in actuarial services, cost recovery, accounting, or pricing. While CHFs have shown to be very competent when identifying and engaging informal, uninsured groups in rural communities, they have proven less capable in managing the business of insurance in Uganda. The small number of participants in individual CHF schemes spread fixed costs across small numbers of participants, creating business models that are often not sustainable. Furthermore, CHFs are limited to a defined geographic area, restricting the size of the potential pool for risk distribution. Concerns of adverse selection and moral hazard are amplified by the small nature of the CFH schemes. Further, by limiting the CHF to

62 "Catalogue of Community Based Health Financing Schemes," PHR*Plus* project, USAID, 2006.

a small geographic area, certain health crises localized within the community can lead to catastrophic risk, leading to cascading failure of the CHF scheme.

Certain innovations reaching Uganda create an opportunity to strengthen CHF schemes through increased coordination, network efficiencies, and reduced transaction costs. New mobile payments services offered through local mobile phone providers create an opportunity for CHFs to reduce transaction costs, obviating in-person payment delivery in communities with no brick and mortar financial institution. Further, socially responsible networking applications, such as those under development through companies such as AppLab Uganda, create opportunities where CHFs could align with one another through mobile communities of practice, offering best practices, tips, and even offer the possibility of policy pooled reserves.

Despite the small number of existing CHF schemes, and the low level of existing coverage (approximately 30,000 Ugandans are covered by CHF schemes), CHF schemes and micro-insurance present unique opportunities to extend a basic level of health insurance coverage to broad cross-sections of presently uninsured Ugandans. In light of the political difficulties facing national public health insurance scheme, CHFs represent perhaps the best, most sustainable opportunity for identifying, and insuring the uninsured.

## SUPPORTING INSTITUTIONS

### MFI SUPPORT

The Association of Micro Finance Institutions in Uganda (AMFIU) is a government-owned company that secures wholesale capital and sells it in chunks at below-market levels to participating microfinance institutions. The AMFIU also advocates on behalf of the interests of MFIs, and is consulted when rules impacting microfinance institutions are under consideration. The goal of the AMFIU is to strengthen the MFI sector and over time graduate a number of MFIs to MDIs, and then MDIs to commercial banks to compete with existing commercial banks. The AMFIU has developed specialized loan products for participating MFIs geared towards increasing MFI lending to the agribusiness sector. The AMFIU has no plans, and had not thus far considered using its resources, to boost health sector financing, though one of its client MFIs recently undertook its first microloan to a health clinic, a 500 shilling microloan for small-batch pharmaceutical acquisition, and the relationship fared well.

### INSURANCE ASSOCIATIONS

The Uganda Insurers Association (UIA) is an umbrella organization representing the interests of the private insurance industry broadly. General impressions of the UIA are positive with regards to advocacy, public education, and outreach. Membership in the UIA is mandatory for licensed insurance companies, though the informal HMOs do not participate in this trade association. The UIA actively participates in, and recognizes the unique needs of health insurance. The UIA could be particularly helpful as a mode for coordinated industry discussion on developments in health, microinsurance and community health schemes.

The Uganda Community Based Health Finance Association (UCBHFA) is the primary association representing the interests of 30 community health insurance (CHI) schemes in Uganda. The UCBHFA advocates on behalf of CHI interests in national government legislation, promotes the development of CHI schemes throughout Uganda, conducts educational programs, and serves as the mouthpiece for CHIs in Uganda. The UBCHFA also maintains active partnerships with each of the three main private not-for-profit medical associations, and focuses on financial access to medical services in rural regions, especially targeting individuals employed in the informal sectors. The UBCHFA provides feedback on issues of health policy, and provided comments and analysis to

the national government for the national health insurance scheme.

Participation in the UCBHFA is voluntary for CHIs, though most CHIs do participate. The UCBHFA, however, has an unsustainable business model. The UCBHFA finances its activities at the national level through a mix of user fees and donor funding. Presently, user fees only account for one percent of the UCBHFA's operating budget; donor funding makes up the shortfall, but donor funding has been tapering off.

## ENFORCEMENT

Enforcement of agreements is vital for effective financing of the health sector. While user fees represent nearly 49 percent of income generated by facilities-based private not-for-profit health service providers, and an even greater percentage of income generated by private for-profit health providers, the vast majority of fees are paid via upfront cash payments. However, many providers offer up to five days for payment for services by long-time patients with a history of good payment. Additionally, insurance claims payments can often take over six months to recover, despite standard 30-day payment clauses in most policies. Medical goods and device suppliers cite difficulties in the gap between the date they must pay international suppliers and the amount of time it takes to receive payment from their clients, often private for-profit and not-for-profit clinics. Medical goods and device importers also cite a six-month delay in repayments, which often requires expensive bridge loans from commercial banks at an average 20 percent interest. A low-cost, rapid enforcement system for claims disputes and debts collection would strengthen the environment for credit expansion locally.

## COMMERCIAL COURT

The Commercial Court is endowed with the powers to fully adjudicate all forms of commercial decisions, from intellectual property rights (IPR) enforcement to bankruptcy actions. The Commercial Court has access to well-trained judges with an understanding of the principles of all areas of commercial law. Further, the reputation of the Commercial Court is relatively positive, based upon interviews during this assessment. While the Commercial Court is largely viewed as an unbiased adjudicator, its biggest drawback is the lengthy time it takes to dispose of cases. The court's administrator claims that the average case is disposed in 320 days from filing, but the World Bank estimates that it takes 540 days. The latter is more in line with the experiences of several of the individuals interviewed during this diagnostic. Such a lengthy process prohibits all but the largest cases, or most patient parties.

## SMALL CLAIMS COURTS

On a positive note, the Commercial Court is set to roll out pilot small claims courts that are intended to expedite smaller-value, simple cases, leaving the Commercial Court's docket only for appeals, cases over $5,000, and cases requiring specialized training, such as IPR disputes. The Commercial Court intends to open up small claims courts in five districts around Uganda, using senior attorneys as administrative judges to hear the cases. Process and evidentiary procedures will be relaxed for these small claims courts, with the intention of speeding through small cases. The Commercial Court pilot program should commence within the next two years.

## BAILIFFS

Bailiffs in Uganda are private sector enforcement agencies, not officers of the court. This can lead to a wide discrepancy in skills, training, and competence. Further, it creates a dynamic where, in some cases, police agencies can and have inserted themselves into the enforcement process, claiming that a police presence is required to effectuate the terms of the warrant issued by the court. According to interviewees, it is estimated that nearly 60 percent of warrants remain unenforced in Uganda. Much of the problem was associated with corrupt local politicians managing local police and security

forces that physically intervene during execution of warrants. This has a direct impact on the ability of creditors to enforce judgments against borrowers, leading to increased costs for capital. Some bailiffs expressed special reservations about enforcing judgments against medical facilities, citing reputational risk within the community for repossessing medical property.

### UGANDA INSURANCE COMMISSION

While the UIC, described in detail above, does not have an adjudicative body, it does maintain a department for members of the public to lodge complaints. For especially egregious complaints, the UIC will consider complaints of policy disputes and lengthy claims repayments, and can ultimately pull, or fail to renew, the license for insurance providers. Notably, some have found this process, and commission members, to have ulterior motives.

### ALTERNATIVE DISPUTE RESOLUTION

Private health providers interviewed for this assessment largely have not availed themselves of alternate dispute resolution (ADR). ADR is largely unfamiliar to private health providers in Uganda, and does not appear in their supplier contracts. This should be spread more broadly, especially in light of existing limitations in the courts' system.

### ATTORNEYS

Lawyers in Uganda are trained and often specialize in areas of commercial law. Further, the Law Development Center provides a fee-based service that will conduct an analysis of all of the laws, policies, and regulations for business start-ups in individual sectors. However, most private for-profit providers claim that legal services are too expensive in many cases and that the slow pace of the courts is often not worth the value of the claim.

## SOCIAL DYNAMICS

Private health sector providers face a daunting challenge in securing adequate finance. Beyond the notion of the "missing middle," where finance is largely inaccessible for small and medium-sized enterprises across the private sector, the health sector faces special challenges: the private health sector must compete with a failing, yet free public health system whose true costs do not seem to be well known.

### LENDER/BORROWER INFORMATION GAP

The private for-profit health sector is still a relatively young industry, dominated by micro, small, and medium-sized medical practices that desire access to finance, but have neither the requisite transaction history with a bank nor an adequate understanding of the basic tenets of lending and finance to understand how to secure financing. For their part, banks are also somewhat skeptical of the private health sector, do not understand the typical business models, cannot properly value medical goods and devices, and are unfamiliar with systemic risks of the health industry. What is more, due to concerns raised by the international economic slowdown, as well as fraud and insolvency in the SACCOs market in 2002–2003, banks tend to be wary about lending to unknown borrowers.

While the credit reference bureau should help to re-inject trust into the financial markets over time, the need for health care financing is necessary in the short term. Stocks are depleting, capital equipment requires servicing, facilities need expanding, and each of these issues requires finance. While the CRB can help establish personal credit histories, this does not change the fact that both parties to private health financing lack comprehension of one another and the business of health.

### CORRUPTION

The issue of corruption in private sector health financing was listed as a significant concern, though due to the low volume of transactions within the health sector, as well as the low levels of government regulation in this sector, opportunities for graft are still low in the private sector. Even though the private health

sector is such a small sliver of its potential, anecdotes of insurance claim "speed payments" to claims adjusters were raised, as was the issue of abuse of claims policies. However, this was largely overshadowed by the rampant corruption in the public sector, raised by public, private, and private not-for-profit firms alike. Anecdotes abounded in the public sector of district health officer favoritism in dispersing primary health care grants and large-scale theft of public goods for private purposes from public hospital's pharmaceuticals and supply stores. Other systematic abuses include public sector doctors allegedly accepting bribes to speed up selected patient wait times. The most egregious instance of public sector corruption revolved around a missing $1million from the public coffers earmarked for vaccinations from the Global Fund. At current volume, corruption has less influence on private health sector financing at present, although this should be watched as the health financing sector grows.

## MEDIA

The media in Uganda reports widely on health-financing issues and, among the large news organizations, presents varied opinions and viewpoints on major issues. Through the media, the public appears to be well informed of major news stories. In the immediate term before, and while the assessment team was in country, two of the local newspapers reported broadly on public and private health sector–enabling environment issues, including the national insurance scheme, a mercurial dispute over licensing Uganda's largest health insurance provider, updates on alleged embezzlement of public health funds from donor organizations and prosecution of the not-for-profits involved in the alleged activities, as well as public health issues, gender concerns, and legislative actions in health.

## ADVERTISING

Health service providers are prohibited from advertising their services. In a country where sophisticated medical equipment is rare, acquiring new equipment can differentiate a health service provider from its competition. Without the opportunity to advertise the equipment to the public, health providers and financiers alike voiced concerns that word-of-mouth advertising limits the value of the investment.


# PROVIDING AND MAINTAINING FACILITIES

Investors need certainty in the laws and institutions that regulate their activities, and certainty in enforcement of these rules for rational business decisions. A well-defined regulatory environment with consistent implementation of rules, laws, and regulations is a prerequisite for an efficient and attractive business environment that enables the private sector to flourish. In Uganda, the rules governing business entry into the health sector, including the startup and ongoing operations of facilities, are beset by outdated rules that do not support efficient business formation, and inconsistent enforcement of rules, policies, and processes that discourage continued investment into facilities.

## LEGAL FRAMEWORK

The legal and regulatory framework governing the start-up and operations of private medical facilities in Uganda is underdeveloped. The absence of explicit formal licensing standards for private sector firms, coupled with a weak business formation regime, creates a significant barrier to market entry for formal PFP health facilities.

### STARTING AND LICENSING A MEDICAL FACILITY

The start-up of PFP medical firms in Uganda is governed by the Uganda Companies Law, 1961, which is based on the English Companies Act.[63] The process for formal business formation and registration in Uganda is complicated and serves as a burden to market entry for PFP health firms. While business registration processes were cited as sources of delay for health sector companies seeking to formalize, especially companies managing small health clinics outside of the Kampala metropolitan area, inconsistent application and disharmony between municipal regulations was raised as a barrier to increased investment in new health facilities across municipal boundaries.

The Medical and Dental Practitioners Statute governs the national licensing requirements for establishing facilities in Uganda. Even though non-medical personnel may have an ownership

interest in a medical facility, for purposes of professional care and quality assurance, each facility must be registered in the name of an individual qualified to provide the services of that facility. While this regulation is not uncommon in the region, there is little rational basis in limiting company registration to medical professionals. This rule conflates registration with facility and service quality control. Limiting registration to qualified medical professionals creates an inferior ownership stake for non-medical investors. Registration confers no obligation that the registrant actually practices at the

63 A fuller description of the Uganda Companies Law of 1961, and in general starting a business, can be found in *Uganda's Agenda for Action* (pp. 15–20). *Uganda's Agenda for Action* can be found at www.bizclir.com.

facility; merely that the registrant be qualified to work in the facility. In many instances observed throughout this assessment, clinics owned by non-medical professionals would engage medical professionals exclusively to provide their name to secure registration.

For private-not-for-profit institutions, alternative opportunities might exist for formation of the company and facility registration. However, there was confusion among stakeholders as to the legality of formation according to these terms within the private health sector. One facility administrator, affiliated with private-not-for-profit faith-based organizations (FBOs) said the hospital was affiliated with an FBO and that it was "incorporated" under The Trustees Incorporation Act. Section 1 (1) of this Act provides that "[t]rustees or a trustee may be appointed by any body or association of persons established for any religious, educational, literary, scientific, social or charitable purpose, and such trustees or trustee may apply . . . to the Minister for a certificate or registration of the trustees or trustee of such body or association of persons as a corporate body."

There are no express prohibitions against non-Ugandans investing in health facilities. Section 13 (1) of the Investment Code Act provides that "[s]ubject to section 10(2), an investor may engage in any type of business enterprise." Though no express restrictions prohibit foreign direct investment in local private sector health companies, there is no coordinated effort on the part of the government to encourage foreign direct investment into the health sector. One interviewee criticized that Uganda Investment Authority does not actively promote investment in the health care field beyond the pharmaceutical industry. Indeed, the Second Schedule to the Investment Code Act does not list "professional services" as a "priority area" eligible for investment incentives;[64] moreover, the Third Schedule specifically includes "professional services" among those areas not eligible for investment incentives.

## IMPLEMENTING INSTITUTIONS

The primary implementing institution for regulating the health sector, as well as the standards for health facilities, is the Uganda Medical and Dental Practitioners Council (the "Council"), established under The Medical and Dental Practitioners Statute, 1996 (MDPS). The Council is a small body, and its regular staff is insufficient to meet its broad mandate. The Council consists of the Chairperson appointed by the Minister of Health, the Director General of Health Services, two representatives of the medical faculties, two representatives of the Uganda Medical Association, one representative of the Uganda Dental Association, and one private practitioner representing the Uganda Private Medical and Dental Practitioners.

The Council has a number of functions under the MDPS (see section 4 of the 1996 Statute), including to:

- Monitor and exercise general supervision and control over, and maintenance of, professional educational standards including continuing education
- Promote the maintenance and enforcement of professional medical and dental ethics
- Exercise general supervision of medical and dental practice at all levels
- Exercise disciplinary control over medical and dental practitioners
- Protect society from abuse of medical and dental care and research on human beings
- Advise and make recommendations to Government on matters relating to the medical and dental professions
- Disseminate to the medical and dental practitioners and the public, ethics relating to doctor-patient rights and obligations
- For the purposes of discharging its functions under the Statute, perform any other function or act relating to medical or dental practice as the Minister of Health may direct.[65]

64 The "Pharmaceutical industry" is listed as a priority area eligible for incentives.

65 There are similar laws, also adopted in 1996, that govern the allied health professionals (The Allied Health Professionals Act) and nurses and midwives (The Nurses and Midwives Act 1996). "Allied Professionals under the first act include, among others, dental technologists, laboratory technicians, pharmaceutical dispensers, ophthalmic clinical officers, psychiatric clinical officers, orthopedic technicians, physiotherapists, health inspectors, and others.

## HEALTH UNIT INSPECTION

Inspections are also a crucial function of the Council. Inspections are sometimes carried out by Council members, but since they are representatives of other groups and thus do not work full time for the Council, the vast majority of inspections is carried out by other parties, such as district health officers.

This responsibility, implemented through the Council Registrar is "to inspect and have full access to all medical and dental health units, acting in accordance with the provisions of this Statute." Other important functions of the registrar are to keep, maintain, and update registers of medical and dental practitioners.

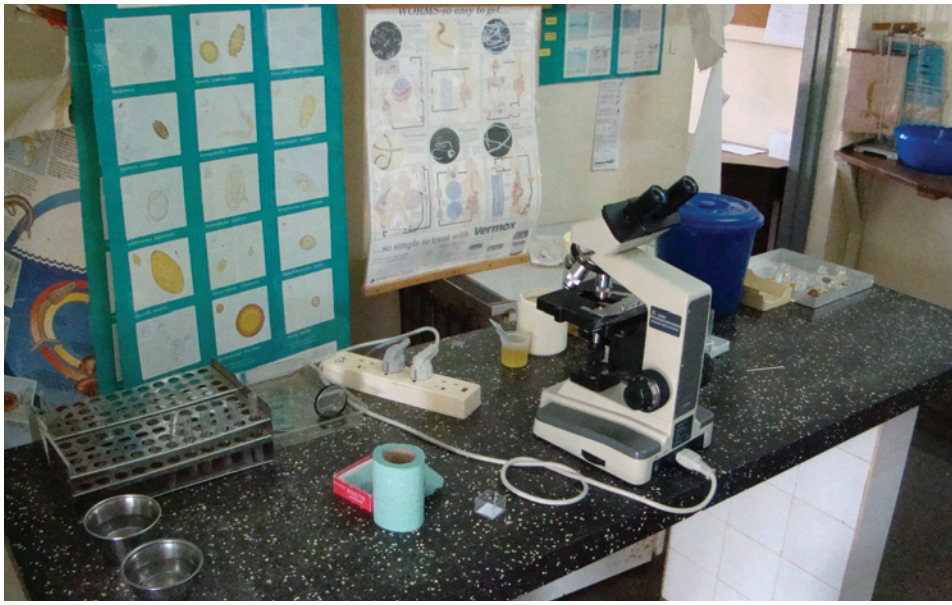
A number of medical practitioners observed that while official standards are modeled on or equivalent to international standards, in practice these standards are not upheld. Due to a lax enforcement regime, oftentimes facilities do not adhere to the standards promulgated by the Council.

The Council has a checklist for health unit inspection. Depending upon the outcome of the review, the Council is authorized to undertake the following actions resulting from their review:

- Renew annual license;
- Authorize a temporary renewal, with full license renewal conditioned upon accomplishing certain objectives assessed during a follow-up inspection;
- Temporarily close down the facility, but authorizing re-inspection after a predetermined period with the right to resume operations upon meeting quality improvement objectives; or
- Permanently close the facility.

This form is then signed by the inspecting officer, and it then goes to the District Directors of Health Services (DDHS) or the Ministry of Health for recommendations.

Despite the Minimum Requirements and the Checklist, there was near unanimous agreement that enforcement of facility standards are ineffective and inconsistently applied.




Inspections were not undertaken with any regularity; sometimes there might be only one inspection every several years (one party mentioned one inspection in five years). Further, the perceptions of quality and professionalism of inspectors varied widely.

Inspections are not the only areas where laws, rules, and regulations exist but are not observed. The need for medical facilities is so great that applications from the private sector to establish them are rarely disapproved. Certificates of need and environmental impact statements may be required, but are not always submitted, and facilities are established despite the lack of such documentation.

## MEDICAL EQUIPMENT FINANCE

Private health facilities are growing in number and size, and while financing for the actual building can be obtained, it is extremely difficult, if not impossible, to obtain financing for equipment and supplies. Although the subject is dealt with in greater depth and detail in the Accessing Credit chapter, it must be mentioned here that a key constraint to a more robust private sector is the absence of adequate financing. This issue must be addressed to enable the private sector to continue to increase its services and availability to the Ugandan public.

Despite the increased popularity of private medicine, the opinion was expressed by a number of health professionals that doctors do not know how to run a medical practice or unit as a business. Thus, doctors are at times unwilling to open their own practice or facility, fearing it may fail.

The assessment team was able to see a number of private medical facilities, ranging from a hospital to a large clinic to a small clinic, which were started and run by companies, and serve the needs of their workforces and families, as well as (sometimes) the local population. These were of a generally high quality and could well serve as models for other facilities of this kind. One of the clinics was run by a company associated with a private hospital, demonstrating how the private sector can be employed in a number of ways to facilitate health care in Uganda.

## SUPPORTING INSTITUTIONS

### MEDICAL ASSOCIATIONS

Medical associations in Uganda suffer from a lack of resources, insufficient membership, and, therefore, a lack of influence in policy development. Despite these significant limitations, medical associations do find ways to be heard. As was indicated in the Implementing Institutions section of this chapter, the Uganda Medical Association has two representatives on the Medical and Dental Practitioners Council, the Uganda Dental Association and the Uganda Private Medical and Dental Practitioners each also have a representative on the Council.

The most significant role of the Council is in licensing and registering health facilities through its registrar. Since the Council is housed within the Ministry of Health, it is perceived by many in the private health community to be part of or controlled by the Ministry of Health. The Council does not serve as a strong advocacy organization largely due to its dependence on the MoH for funding, and its perceived lack of independence from the MoH in policy and advocacy.

Another of the Council's functions is to monitor and exercise general supervision and control over and maintenance of professional medical and dental educational standards, including continuing education. The Council does not run its own continuing professional development (CPD) courses, but it does provide a CPD personal diary for medical and dental practitioners. This diary is to be presented for re-licensing purposes. CPD includes activities such as personal study, personal research, and clinical meetings in addition to workshops and conferences that must have been approved by the MDPC.

The Council can delegate its role in minimum continuing education to professional associations,[66] and at the national level, CPD is coordinated by a national steering committee (NSC) and supported by the government. The NSC Secretarial is housed at the Department of Human Resource Development, Ministry of Health, and "there is a clear CPD administrative structure that is well coordinated from the national level through to the district."[67]

However, no one interviewed by the assessment team mentioned an organized program for CPD. There might be a formal administrative structure, but little in the way of CPD programming. Unfortunately, the various medical associations hold few CPD courses. Hospitals and medical facilities organize continuing education events to help fill the gap.

### UGANDA MEDICAL ASSOCIATION (UMA)

The Uganda Medical Association has limited resources,little money and no website. It receives funding from membership dues (subscriptions) and from conferences it runs. There is a predictable spike in dues in the areas hosting conferences. Of the approximately 2,000 doctors in Uganda, at any given time there are only about 200 paid-up members.

66 Samson Ndge, "Continuing Professional Development: A Southern Perspective," *International Hospital Federation Reference Book 2005/2006*, at p. 43.

67 Id.

Despite its lack of resources, the UMA does feel that its voice is heard. It is a member of the Task Force on Conditions in Health Services, and it provides two members to the MDPC.

### UGANDA PRIVATE HEALTH UNITS ASSOCIATION (UPHUA)

Uganda Private Health Units Association (UPHUA). The UPHUA, started in 2005, was organized for private health units to advocate for the government to facilitate private health. Some of the things advocated for include:

- Credit lines for private health units
- Equipment
- Medicines
- Vehicles

The reasoning behind these requests is that private health units often provide services for which they are not reimbursed, such as counseling for those receiving anti-retrovirals, providing other services for free even if the patient only paid for a diagnosis, and using vehicles to deliver medication to patients who cannot come to the unit. The UPHUA has about 200 members (including clinics), and has had some success, but admits that the process is slow.

### FAITH-BASED ORGANIZATIONS (FBOS)

Many health units of all sizes, from basic clinics to large hospitals, are run by three FBOs—Catholic, Protestant, and Muslim, which engage with one another in sharing experiences and best practices in their own internal regulatory schemes. These faith-based FBOs provide an added level of regulation and oversight, beyond that provided by implementing institutions such as the MDPC. For example, the Uganda Catholic Medical Bureau (UCMB) has guidelines for the establishment of Catholic health units.[68] These guidelines provide the requirements for a health unit becoming accredited as a unit by the UCMB, *in addition to* the requirements of applicable Ugandan law and regulation. To satisfy the applicable laws and regulations, the unit has to be registered by the Council and pass inspections by the DDHS. However, at least one year of operation has to be completed before the UCMB will consider the unit for accreditation. The UCMB will look at the unit's operation and governance during that year, and make its own determination as to accreditation by the UCMB (separate from the registration and licensure by the government).

## SOCIAL DYNAMICS

### PROFESSIONAL ORGANIZATIONS

Professional organizations are often vehicles for advocacy and lobbying. As mentioned earlier, the professional associations are not strong at all, and despite their wishing to advocate, their voice could be stronger.

Adding to this situation is a perception on the part of the private sector that the Ministry of Health "does not listen to it." Whether this is in fact the case or not, the perception does exist, and it colors the actions of the private sector. Indeed, one private practitioner said that the Ministry of Health is interested only in the public sector health units. Again, this is just an opinion, but it does reflect thinking in some parts of the private sector.

68 "Guidelines for the Establishment of New RCC Health Units," (Oct. 20, 2003).


# GOVERNING THE SYSTEM

The form of the governance architecture for a health system can have great impact on the level of participation of private health providers within a health system. Centralized, "top-down" policymaking with little opportunity for stakeholder input and low accountability can raise opportunities for graft, and reduce entry by private sector participants. However, extremely decentralized decision-making structures can also negatively impact the private sector's ability to effectively collaborate in policy development. Accountability, representation, and ultimately private sector participation in the health system and health policy development are critical in an industry that has historically been the exclusive province of public sector providers.

In Uganda, the Ministry of Health, the Ministry of Finance, and the system of local governments work together to govern and direct the formal health system. In addition to these governmental institutions that regulate the health system generally, private sector participants have established their own governance structures. PNFPs face rules and regulations beyond minimum legal requirements. PFP facilities largely self-regulate, though even PFPs have begun to form self-regulating organizations to provide structure to the PFP segment of the health system.

Uganda has a well-developed legal framework for the public sector delivery of health services. The budget process is a good example, as this process systematically evaluates the performance of individual districts through measures that are integrated with the overall health strategy. Using this information, allocations are made to the districts, which then distribute money to individual facilities. However, unlike the budget process, the system of regulating medical facilities and medical professionals in Uganda is fragmented, mainly due to resource constraints, but also due to poor data collection and distribution. PFPs do not receive subsidies by the national government; thus, they do not compile requested data for reporting to regulators.

Without performance data, the MoH and others who bear the dual responsibility of regulating the health sector while also improving national health outcomes are not cognizant of the impact of the private sector. Thus, the private sector is offered little meaningful opportunity to shape health polices and sector regulations. Because of the lack of a sound regulation system, as well as limited interaction between the budget and regulation systems, the private sector is left lacking basic foundational rules upon which to build additional governance structures.

The PNFPs have worked within this context for many years. For example, the Muslim Medical Bureau has its own set of standards that its facilities and workers must meet. Other not-for-profit health delivery system such as the informal system of health services provided through employer-sponsored medical facilities have also developed their own regulations and guiding documents, with the effort to make them congruent with MoH regulations.[69] In both cases, regulation is cited as a gap, which they have sought to fill by providing logistical assistance to the regulators for supervisory and accreditation visits.

However, for PFP facilities and professionals, there is no clear professional organization or association present to provide structure. While

69 The HIPS project, funded by USAID, works with 88 clinics throughout the country. It operates by working with private companies to provide health services to their employees and the surrounding community either free of charge or for a nominal cost.

organizations do exist, such as the National Association of Private Hospitals and the Private Medical Practitioners Association, no single organization commands the authority to establish sector-wide standards of practice, facilities standards, or ethics standards.

## LEGAL FRAMEWORK

The National Constitution of 1995 expresses the mandate for the government of Uganda to "take all practical steps to ensure the provision of basic health services to the population."[70] In 1993, public health care was devolved to the local governments, and in 2004 the responsibility for providing health care at the local-government level clarified the idea that the local governments would be able to better serve the population given their proximity and understanding of the needs.[71]

To carry out the mandate of providing health for the people of Uganda, two main Ministry of Health documents lay out the national approach. The first of these is the National Health Policy, most recently passed in 1999. This document establishes the minimum health care package, which it strives to make available to all Ugandans. Also outlined in this document are the roles that the government intends to fulfill to make this possible, among them is to "clarify the relationship between the key stakeholders in the system."[72] The policy strives to engage the private sector in, among others, data collection, education, and participation in distributing care to areas not served by public facilities. The second document, the Health Sector Strategic Plan II (2005/06-2009/10), which is only available in final draft form, outlines in more detail the objectives, goals, and actions that the ministry will undertake in order to provide the minimum package of health to all Ugandans.[73] These documents clearly identify the correlation between health and poverty, and relate the health plan to the Poverty Eradication Action Plan.[74] Additionally, performance metrics established within these documents take into account the Millennium Development Goals, setting up data to be easily shared across collaborators or in relation to other entities.

### HEALTH BUDGET DEVELOPMENT PROCESS

The Budget Development Act of 2001 outlines the process for budget formulation. The government budget is an iterative process between the central Ministry of Finance, various local governments, and other key stakeholders. First, the Ministry of Finance provides provisional budgets to the local governments. Using these estimates as starting points, the local governments then work on their individual budgets, allocating money to the various programs within their districts. Proposed local government budgets are in turn resubmitted to the central government for consideration in the final budget. The Local Government Finance Commission has the authority to both advise the local governments in this process and act as a mediator for any disputes that arise. The MoH also participates in the process, providing budgetary requests through its discretionary line budget. Through this role, the MoH serves two functions: first, it ensures that the health budget priorities among the local governments reflect those established at the central level, and second, the MoH advocates on behalf of the health budget line items for distribution among local governments.[75]

Within the private sector, traditionally only PNFPs have had the opportunity to provide meaningful inputs into the government's health budget process. Further, PNFPs receive subsidies in the form of Primary Health Care grants (PHCs) from the government budget to provide specific services. As with all budgetary decisions, the Chief Administrative Officer (CAO) has final discretion on how the budget may be spent, although there are restrictions on how much this can vary from the submitted budget. In some opinions, decentralization has created a situation where the local governments compete for the limited funds available at the central level, generating little revenue on their own and

70 National Constitution, 1995, art. XIV b.
71 Local Government Act of 2004, ch. 243.
72 National Health Policy, p. 10.
73 Health Sector Strategic Plan II (2005/06–2009/10 (HSSP II).
74 The update of this plan is renamed the National Development Plan.
75 HSSP II, p. 73.

creating a great deal of dependency upon the central government. While performance indictors are agreed upon as part of the initial budget meetings, the budget can vary by 20 percent.

## PUBLIC PRIVATE PARTNERSHIP FOR HEALTH

Though traditionally the health authorities have underestimated the role of the private sector, the trend in new national health policy documents shows increased recognition about the role that the private sector plays. The government shows more interest in identifying innovative approaches to utilize the private sector's substantial presence to further the delivery of health to the population. To this end, a Public Private Partnership for Health office (PPPH) was created to formalize the interactions between the sectors. Guidelines are being established to better outline the relationship between the two sectors. However, these documents do not establish a process for enforcement or clarify how authority to establish the guidelines is assumed. With the most recent Health Sector Strategic Plan II, a public-private partnership working group, is named as one of the nine working groups,[76] showing that they have had input despite not being formalized.

## ACCREDITATION OF FACILITIES AND PROFESSIONALS

Central to any health system are the standards that must be achieved in order to operate as a health facility or for a professional to deliver health services. In Uganda, health standards also exist through the National Supervision Guidelines for Health Services, which was finalized in 2000. Supervisory visits are coordinated through the Department of Quality Assurance within the Ministry of Health and done in coordination with district health officers. The covered services for these guidelines are "all the [45] districts in Uganda and at all levels of health service delivery."[77] Confusion exists as to the extent to which PFPs are, or should be subjected to standards governing public and PNFP hospitals and clinics. Though many of the PNFP and PFP facilities attempt to have their facilities inspected, they report that it is difficult given the limited resources available. While the guidelines are clearly outlined, a successful supervisory visit is not directly tied to accreditation. Further, interviews showed that consumers of health care did not consider accreditation when selecting a medical facility.

Overall, the laws and policies that govern the health system and the integration of performance metrics are quite impressive. However laws and policies are not readily accessible in written form. The Law Development Centre is mandated to produce copies of all laws and policies and make them accessible to the legal community, yet due to shortages of resources and equipment, many are left without access.[78]

**KEY LAWS**

- Constitution of the Republic of Uganda, 1995
- The Budget Act, 2001
- The Local Government Finance Commission Act, 2003
- The Local Governments Act

76 Id.
77 National Supervision Guidelines, p. 11.
78 Interview with Law Development Centre.

**KEY POLICIES AND GOVERNING DOCUMENTS**

- National Health Policy, 1999
- Health Sector Strategic Plan II (Final Draft)
- Public Private Partnership for Health (Draft)

The most recent updates of these laws and policies have not been finalized, leaving draft forms of the documents to stand in as laws. However, the greatest weakness is not in the laws themselves, but poor enforcement of the laws.

## IMPLEMENTING INSTITUTIONS

The Ugandan health system depends on various agencies to implement its vision to deliver a minimum package of care to all Ugandans. The implementing institutions help to ensure that care is provided throughout the regions and that results are appropriately monitored and reported. While the public and PNFP sectors participate in the health policy-making system, the PFP sector operates outside of this system, not receiving governmental funds and not contributing to policy development. This has created a dynamic whereby the PFP sector is seen as separate from the rest of the system, leaving its benefits unaccounted for, and its resources underutilized.

### GOVERNMENTAL ENTITIES

The Ministry of Health is the agency responsible for overall supervision and guidance of the health system in Uganda. The MoH's National Health Policy and the Health Sector Strategic Plan (HSSP), described above, establish the objectives and goals that will guide the system.

The local governments are responsible for both implementing the activities necessary to the HSSP and for monitoring achievement shortfalls. Each local government entity has a district health officer (DHO.) This officer is responsible for choosing the programs and initiatives that will best achieve the health outcomes in his/her respective district. In practice, this means that the DHO is responsible for allocating the portion of the local budget related to health. Additionally, the system of supervising public health facilities, from regional hospitals to health centers, falls under the governance of the DHO. Therefore, employees of the DHO perform supervisory visits to these facilities in conjunction with central-level teams. Given this supervisory role, the entities are responsible for reporting data to the DHO. This is true for all facilities within the district, whether they are public or private. While public and PNFP health facilities are required to report their data, there is no incentive for PFP facilities to report their data because they do no report to the DHO, and also receive no funding from the DHO. PNFPs are required to report their data to two separate entities: the DHO and the Central Ministry of Health. This duplication of reporting results both increases the administrative costs for running PNFPs and creates a risk that results will skew overall performance measures.

The Planning Department within the Ministry of Health has the responsibility for annually compiling all the data received from the districts and evaluating the performance of the health system against the HSSP. It is notable that the goals of the HSSP are well aligned with Millennium Development Goals, as well as the overall development plan for the country in the form of the PEAP.

### PRIVATE NOT-FOR-PROFIT ENTITIES (PNFPs)

As previously mentioned, certain PNFP groups have established their own health systems, organized to set central administrative policies and procedures for the facilities and staff owned and operated through their organization. For example, the Muslim, Protestant, and Catholic Medical Bureaus each have their own reporting, financial, and staffing regulations to govern the facilities in their system, while making efforts to make sure these are aligned with the Ministry of Health guidelines. Given the long-standing relationships between these entities and the government of Uganda, PNFPs actively seek the

**KEY IMPLEMENTING INSTITUTIONS**

- Ministry of Health
- District health offices
- Religious medical bureaus (private not-for-profit)

opportunity to share information and data with partners, including the government, and see this as a means to advance their mission of providing health services. While the government provides subsidies to these systems, there is a call to tie this support to service in the form of service-level agreements.

## SUPPORTING INSTITUTIONS

Within any health system, there are several organizations that are not direct policy makers or governing bodies but still contribute to the system of governance. Their role is twofold: to influence the entities that do directly govern, and in many cases to help reinforce laws and regulations. For example, professional certification bodies will often align their certification requirements with the treatment guidelines and policies of the health ministry so that they are enforced through the certification process. In Uganda, supporting institutions have not reached a critical mass, nor do they have a process for gathering feedback from their members. For this reason, among others, the supporting institutions outlined below have little influence in shaping the governmental policy or budgeting process.

### PROFESSIONAL COUNCILS

In Uganda, there are four professional councils—the Uganda Medical and Dental Council, the Nurses and Midwifery Council, the Pharmacy Council, and the Allied Health Council. Every medical practitioner, public sector, PFP, or PNFP, must be licensed through the appropriate professional council, though in practice, membership in the council is not enforced. In addition to establishing base licensing standards, the professional councils are intended to advocate on behalf of their membership in policy formulation within the MoH. Funding constraints and inadequate human resources limit the ability of professional councils to enforce standards.

The relationship between the professional councils and the MoH is blurred. The salaries of registrars in each of the professional councils are funded by the government, though support staff are financed by the professional councils. Three of the four councils are physically housed within the MoH building. Though officially separate from the MoH, the medical councils are heavily dependent upon the MoH for personnel and office space, which conflicts with the advocacy role of the councils.

The professional councils serve as a linchpin for creating and maintaining professional standards for the health sector, and represent the single most important source of organization within the profession. The professional councils are the only bodies with some degree of oversight over all segments of the professions—PFP, PNFP, or public sector. The advocacy role they provide is very important, as is their independence from MoH influence.

### PROFESSIONAL ASSOCIATIONS

In addition to the professional councils discussed above, other supporting institutions include professional associations. Distinct from the councils, associations do not grant certifications, but rather are membership organizations offering tailored services to constituent members. Within Uganda, associations are extremely weak, and new ones are formed frequently. This stems from the fact that there is no one association that is recognized or regarded as the professional association of choice, either for private or public practitioners. While in some cases a representative from an association will sit on a policy council, showing the willingness on the part of the government to cooperate with such groups, there is no mechanism for reflecting the concerns of its members to the government and vice versa. If there was a process to gather the

opinions and concerns of constituents and represent these as a whole to the policy process, these associations would exert greater influence. Interviews with some professional associations revealed that there is some interest in using these groups to enforce quality standards within the private sector, and to use them as a forum for consumers to voice their complaints and concerns.

## CONSUMERS

During interviews, many participants stepped out of their official roles to describe their personal experiences as consumers of health care. There are a few patient advocacy groups that represent the needs of patients in various forums. However, many of these groups are aligned with specific diseases rather than holistic patient health, leaving a void for advocacy on behalf of basic care and services. Within any system, the power of civil society to demand compliance with professional standards, of either doctors or clinics, is very significant. Yet, in the case of Uganda, there is neither critical mass among patients nor a venue to lodge concerns or complaints, such as an ombudsman or office within the councils or associations.

## ACCOUNTABILITY

Auditing mechanisms exist in Uganda to ensure the quality of the system of care and the protection of resource flows. The MoH Quality Assurance Department, in conjunction with the local governments, is the entity responsible for supervisory visits to ensure that health facilities are meeting the basic standards outlined in the Health Guidelines, as previously discussed. Should a facility not meet the guidelines established by this department, technical assistance or training is deployed.

In theory, citizens are able to provide feedback regarding perceived corrupt practices through the office of the Inspector General of Government (IGG). This organization has the mandate to fight corruption, promote good governance, promote the rule of law, and enforce

the municipal code. During the course of this assessment, many interviewees cited corruption as an important factor diminishing the quality of the total health system. Anecdotes were rife with reports of leakage of health funds and theft of drugs from public facilities. Admittedly, the IGG was unsure of what actions it would pursue should a complaint of drug unavailability be lodged, given the underresourced system.

Finally, an independent "watchdog" organization, the Anti-Corruption Coalition of Uganda (ACCU), serves as an umbrella organization, coordinating activities among several like-minded organizations to point out incidences of corruption in Uganda and advocate on behalf of stricter accountability measures. According to the ACCU, corruption occurs when intended monies or services do not reach the appropriate recipient in the appropriate time or quantity. In the context of health services, the delayed release of funds or an unfulfilled procurement

**KEY SUPPORTING INSTITUTIONS**

- Professional Associations
- Civil Society
- MoH Quality Assurance Department

may be viewed as a form of corruption. The coalition also advocates on behalf of the public, drafts position papers on policies, and works to inform people of their rights.

## SOCIAL DYNAMICS

Even with the shared understanding of the system, these relationships and beliefs fail to form a strong system of governance. Once again, the private sector is bifurcated between the PNFPs and PFPs, and a dynamic is created where the former is seen as contributing to the health needs of the country, while the latter is perceived to be motivated by profit. By examining the social dynamics, there is some indication of how these perceptions are formed and continue to persist.

### USE OF THE PRIVATE SECTOR

By all accounts, a large proportion of health services within Uganda are supplied by the private sector. By some estimates, 60 percent of health care is provided by the private sector.[79] It is widely accepted that for those who can afford to do so, care is sought through the private sector. In written documentation, the role of the private sector is recognized and valued. However, some interviews revealed a less positive tone about the inclusion of the private sector. The government's weak ability to govern the public sector has resulted in a private sector that has filled the regulatory gap through self-regulation. The public sector is not invested in the regulation, supervision, or monitoring of the private sector. While some collaboration is necessary and does occur, for example, in the case of the medical supply chain system, on a larger scale the public sector views PFPs as a competitor, rather than a collaborator.

### DUAL PRACTICE

One trend that significantly influences the social dynamics of the system is the prevalence of dual practitioners. There is not always a clear distinction between the different needs of the private and public sector. For individuals who are asked to participate in committees or otherwise represent the concerns of the private sector in a policy process, this may lead to mixed prioritization. While dual practice is increasing the access to care for Ugandans, the system would benefit from having clear distinctions between the sectors, for which the first step would be to acknowledge this practice and create venues to address it.

### LEAKAGE OF FUNDS

The leakage of funds, as well as medical equipment and drugs, is not well documented. While there is documentation of both the amount originally allocated and the resulting effect of the allotment through the performance indicators, there is no system for determining whether funds have reached their intended recipient. Additionally, some interviewees reported confusion regarding how they would determine if HIV/AIDS drugs actually reach their recipients, given that the government does require records regarding to whom the drugs are distributed.

### PUBLIC PERCEPTION OF HEALTH CARE

Among interviewees outside of the health sector, health is seen as one of many issues the government must address to improve the quality of life in Uganda. While some public and social marketing campaigns have been launched to educate Ugandans about good health practices, aside from the presidential declaration that health care will be free of charge, there is not one champion for the cause of health as a development mechanism.

79 HSSP II, p. xx.


# APPENDIX: COMPILED RECOMMENDATIONS

## DEVELOPING HUMAN CAPACITY

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| **1.0 Public health workers generally provide poor service delivery in Uganda; one cause for this is weak managerial oversight** | **1.0 Enhance managerial oversight within public health facilities.** | 1.0 Enhanced managerial oversight where health workers are held accountable for their performance could improve service delivery and quality of care | 24 months total | High | High | Medium | Medium |
| | 1.1 Engage with MoH to consider a staffing model whereby managers are placed in management positions while clinical professionals focus on their core competencies; consider altering recruitment policies to include trained managers to run health facilities, thereby freeing clinicians to focus on clinical practice | | Month 1–8 | | | | |
| | 1.2 Engage PFPs and PNFPs which generally currently implement best practice staffing models (i.e.: alignment of competencies to positions) to lend expertise and best practices; consider creating a cross-sector PPP working group to address the issue | | Month 2–8 | | | | |
| | 1.3 Understanding that changing MoH recruitment practices will take time, engage with stakeholders to design basic management training for health facility managers which will likely still include clinical professionals in many locations | | Month 2–4 | | | | |
| | 1.4 Conduct management training seminars for a pilot group | | Month 5–7 | | | | |
| | 1.5 Adjust management training based on pilot results and roll out nation-wide | | Month 8–14 | | | | |
| | 1.6 On a parallel track, develop training focused on improving the attitude and general professionalism of health sector professionals so that staff are more responsive to managers; leverage recent MoH/Capacity Project research regarding the attitudes and motivation of public sector employees | | Month 3–5 | | | | |
| | 1.7 Conduct professionalism training seminars for a pilot group | | Month 6–8 | | | | |
| | 1.8 Adjust professionalism training based on pilot results and roll out nation-wide | | Month 9–15 | | | | |
| | 1.9 Based on movement in tasks 1.1–1.2, assist MoH in implementing new staffing model in health facilities which also includes penalties for absenteeism, etc. | | Month 9–24 | | | | |
| * Initiatives can run simultaneously<br>** We acknowledge that there are several causes for poor service delivery and poor management is just one of them. While a larger effort should be made to change the staffing structure at health facilities, in the interim, clinical professionals in charge of facilities should receive additional management training and policies should be put in place to penalize individuals who do not show up for work, etc. | | | | | | | |
| **2.0 Uganda's national regulatory Councils have limited capacity to enforce standards and assure quality within the health professions.** | **2.0 Build on the work of the Capacity Project and other stakeholders to enhance the capacity of the four Councils responsible for regulating health professionals** | 2.0 Higher quality health care delivered by licensed practitioners as well as a more mature industry which faces legitimate regulation and consequently also begins to engage in self-regulation | 18 months total | High | High | High | High |
| | 2.1 Support moving the Councils from the MoH; consider funding a locale where the four Councils could share administrative services in order to preserve their intended independence from the Government | | Month 1–6 | | | | |
| | 2.2 Consider programming to streamline operations at the Councils; re-design the licensing process whereby licensing applications may be submitted online or through the mail | | Month 7–9 | | | | |

## DEVELOPING HUMAN CAPACITY (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 2.3 Propose that Councils move to a requirement for licensing biannually (instead of annually) to improve compliance and lessen the annual workload | | Month 7–9 | | | | |
| | 2.4 Conduct a public awareness campaign so that medical personnel understand registration and re-licensing requirements as well as punitive consequences for non-compliance; foster a public private campaign which includes universities, public facilities, private associations, etc. | | Month 10–18 | | | | |
| | 2.5 Provide technical support to the Councils to enhance their enforcement role despite their limited resources; consider such punitive actions as publishing in the newspaper the name of medical personnel with expired licenses; also consider monetary fines | | Month 10–18 | | | | |
| * The Councils are meant to be completely independent of the Government. Therefore, neither the MoH nor the MoES should have significant influence over the Councils. They should be located separately from both ministries and should have a formal, professional relationship with both.<br>** The Councils need to be clear regarding the punitive consequence for non-compliance with licensing requirements. These consequences could include monetary fines, public disclosure, and possibly jail time. A few publicized cases would likely start to change behaviors.<br>***USAID's Capacity Project, which has worked extensively with the Councils, would be a logical partner to help implement this work. | | | | | | | |
| **3.0 The traditional and complementary medicine (TCM) sector is unregulated and left out of the formal health care system, despite serving as the primary care provider for an estimated 60% of Ugandans.** | **3.0 Support the integration of traditional and complementary medicine (TCM) into the national health system while ensuring enhanced regulation.** | 3.0 Enhanced patient safety due to the enhanced skills and knowledge of TCM practitioners and increased access to safe primary health care for Ugandans who choose traditional healers | 24 months total | High | High | Medium | Medium |
| | 3.1 Support the Government's existing task force to develop a code of ethics and standards of practice for the TCM sector; ensure compliance with international standards | | Month 1–10 | | | | |
| | 3.2 Collaborate with medical training institutions, MoH, and MoES to include traditional medicine in medical training curricula | | Month 1–8 | | | | |
| | 3.3 Develop and launch a public education campaign around the benefits of TCM as a component of primary health care as well as the risks of using unregulated practitioners | | Month 1–8 | | | | |
| | 3.4 Support the establishment of a professional Council with the responsibility of registering, licensing, and monitoring the TCM sector | | Month 10–18 | | | | |
| | 3.5 Enhance the capacity of associations and organizations of TCM practitioners in order to encourage the sector to mature | | Month 18–24 | | | | |
| * Initiatives can be implemented simultaneously<br>** We understand that this is a difficult sector to regulate; however given the reliance of the Ugandan population on TCM, the investment in the sector will be an important one. Return on investment may take time as this sector is dispersed and disorganized. Engaging with international organizations/partnerships and observing international standards will lend credibility to the sector. | | | | | | | |
| **4.0 Many traditional birth attendants (TBAs) who have received insufficient training contribute to the country's maternal mortality rate through mismanagement of high-risk pregnancies** | **4.0 Strengthen and integrate TBAs into the national referral system** | 4.0 Lower maternal mortality rates due to a referral system where traditional birth attendants refer high-risk pregnancies to formal facilities | 18 months total | Medium | High | Medium | Medium |
| | 4.1 Strengthen advocacy for the adoption of a formal referral process for TBAs | | Month 1–4 | | | | |

## DEVELOPING HUMAN CAPACITY (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 4.2 Develop a basic training course for TBAs to improve referral rates for high risk pregnancies; collaborate with a body such as the Uganda Traditional Healers Association and/or the National Chemotherapeutic Research Center as well as allopathic practitioners/facilities | | Month 5–7 | | | | |
| | 4.3 Provide basic training for TBAs starting with a pilot group; use as a model the training which is held at Matany Hospital; as an incentive, Matany Hospital offers TBAs 1,000 shillings for each high-risk pregnancy referred | | Month 8–10 | | | | |
| | 4.4 Roll out training nation-wide | | Month 11–18 | | | | |

* Use of TBAs is prominent across Uganda. While these individuals are essentially independent practitioners, they can and should be integrated into the formal public health system. The example of Matany Hospital is a valuable one where a nominal fee encouraged TBAs to refer high-risk pregnancies. By exposing TBAs to the formal health system, there is also increased likelihood of enhancing their skills and overall awareness. TBAs will likely need to be addressed in some fashion in order to improve Uganda's high maternal mortality statistics.

## DELIVERING GOODS

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| **1.0 Uganda's private sector supply chains are drastically undercapitalized and are generally neglected or ignored by policy makers.** | **1.0 Give technical assistance directly to manufacturers and to importers/wholesalers ("Williams Street"), and look into improving their access to capital** | 1.0 Improved business processes and greater access to credit should lead to more efficient supply chain management, fewer stockouts, and a private sector that is better prepared for anticipated growth. | 18 months total | High | Moderate to High | Moderate to High | Medium |
| | 1.1 Offer technical assistance, including management and IT consulting | | Month 1–3 | | | | |
| | 1.2 Undertake competitiveness assessment to identify possibilities for local production of basic active and inactive ingredients (e.g., pharmaceutical sugar and starch, artemisin) | | Month 1–8 | | | | |
| | 1.3 Engage with Williams Street vendors to collaborate on development of a code of ethics for importers and wholesalers | | Month 2–6 | | | | |
| | 1.4 Dedicate one or more technical experts for a year to work with the Manufacturers' Association and/or Williams Street on importing best practices. | | Month 6–18 | | | | |
| | 1.5 Co-finance the purchase of modern software, IT equipment, and enterprise resource planning (ERP) systems | | c. Months 7–12 | | | | |
| | 1.6 Consider revolving loan guarantee program, offered through banks whose loan officers have attended donor-sponsored instruction on the business of health and systemic health financial needs. | | Month 12–18 | | | | |

## DELIVERING GOODS (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 1.7 Help Williams Street draft a code of ethics, and identify enforcement options | | c. Month 12 | | | | |
| | 1.8 Continue with technical assistance at all levels to include forecasting, warehousing, inventory management, and freight movement. Assist local manufacturers with expansion, as needed | | Month 13–18 | | | | |
| **2.0 Uganda's public sector supply chains are handicapped by problems at the National Medical Stores (NMS), excessive procurement decentralization, and by a tender system that is not optimized to the needs of the medical sector.** | **2.0 Determine whether additional technical assistance to the NMS is appropriate and feasible. Consider a project or activity to deliver technical assistance at the district/subdistrict level to local hospital pharmacies, subdistrict managers, and DHOs on adopting procurement processes. Work with the government to amend the PPDA.** | 2.0 More efficient public supply chains will lead to better public health outcomes, particularly the reduction of stockouts. A more flexible PPDA will allow faster and more efficient procurement and should lower costs for drugs in the public sector. | 18 months total | High (if new PPDA is passed and NMS is fixed) | High | Medium | Medium to High (if NMS can be fixed) |
| | 2.1 Develop stakeholder group to review PPDA and make recommendations for changes | | Month 1–5 | | | | |
| | 2.2 Engage with stakeholders at the district/subdistrict level, especially DHOs, for a needs assessment | | Month 2–8 | | | | |
| | 2.3 Engage with NMS for a needs assessment and also to determine NMS' capacity for (1) real reform, and (2) absorbing technical assistance | | Month 1–4 | | | | |
| | 2.4 Draft and submit recommendations for changes to PPDA | | Month 6–8 | | | | |
| | 2.5 In collaboration with donor organizations, and in cooperation with MoH, develop training materials and a workforce training program for districts and sub-district employees. | | Month 6–14 | | | | |
| | 2.6 If appropriate, develop plan for targeted technical assistance to NMS, with particular emphasis on logistics, last-mile issues, and the problem of stockouts. | | Month 11–14 | | | | |
| | 2.7 Build advocacy within civil society to apply pressure to the GOU until changes have been enacted to the PPDA. | | Month 9–18 | | | | |
| | 2.8 Deliver training to subdistrict managers and hospital pharmacies | | Month 6–18 | | | | |
| **3.0 Uganda's private pharmacies suffer from undercapitalization, a lack of professionalism, and a drastic shortage of pharmacists.** | **3.0 Provide technical assistance to the pharmaceutical industry to provide additional sources of "supply" for information on best practices in the pharmaceutical sector, in pharmacy management, and in developments in drug laws. Strengthen advocacy efforts and provide alternate information sources for consumers to focus "demand" and apply pressure for improvement of the pharmaceutical profession.** | 3.0 Improved business processes and greater access to credit should lead to more efficient supply chain management, fewer stockouts, and a private sector that is better prepared for anticipated growth. | 12 months total | High | High | High | Low to Medium |
| | 3.1 Locate and encourage local NGOs with capacity to develop medical consumer advocacy. | | Month 1–2 | | | | |

## DELIVERING GOODS (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 3.2 Investigate the possibility of incentives for educating and training more pharmacists. Connect local pharmacists with international professional societies, and manufacturing organizations such as the ABPI (Association of British Pharmaceutical Industries) | | Month 1–4 | | | | |
| | 3.3 Develop professional skills development training for dispensers to capture international best practices. | | Month 3–6 | | | | |
| | 3.4 Offer training to pharmacists in modern best practices, not only in technical aspects but in pharmacy management as well. | | Month 6–12 | | | | |
| | 3.5 Work with the NDA, physicians, and pharmacists to improve consumer access to information about drugs, potentially through additions to mobile platforms and also through a customer information telephone line. | | Month 3–12 | | | | |
| | 3.6 Target technical assistance to the retail pharmacy organization and to the largest retail pharmacy chains | | Month 6–12 | | | | |

## ACCESSING FINANCE

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| **1.0 A lack of credit history and a perception of low business acumen among private health providers creates concerns of repayment risk among financial institutions, raising already high interest rates.** | **1.0 Develop health sector-based trainings in business practices and basic finance.** | 1.0 Improved business processes and skills trainings should improve the quality of loan applications, leading to a greater likelihood of financing. | 18 months total | High | High | High | Medium |
| | 1.1 Engage with business schools and medical schools to collaborate with local financial institutions and representatives of medical councils to develop and disseminate baseline criteria for business skills training seminars | | Month 1–6 | | | | |
| | 1.2 Engage with stakeholders to design basic business skills trainings to health sector providers | | Month 7–9 | | | | |
| | 1.3 Engage with stakeholders to design instruction around the health business for financial institutions | | Month 7–9 | | | | |
| | 1.4 Conduct training seminars in Kampala | | Month 10 | | | | |
| | 1.5 Conduct training seminars regionally | | Month 11–14 | | | | |

## ACCESSING FINANCE (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 1.6 Develop training of trainers program within medical associations to replicate seminars. | | Month 11–14 | | | | |
| | 1.7 Collaborate with Business School and Medical School to assess feasibility of building upon seminars to integrate business skills training into their elective curricula. | | Month 15–18 | | | | |
| **2.0 Few private for profit health sector companies have access to low-interest financing.** | **2.0 Develop and roll out a loan portfolio guarantee program for the private health sector.** | 2.0 A significant increase in the number of loans approved for the private health sector that facilitates relationships between commercial banks and the health sector. | 24 months total | High | High | High | Medium |
| | 2.1 Engage with commercial banks to identify strategic partners willing to participate in a loan portfolio guarantee program. | | Month 1–12 | | | | |
| | 2.2 Develop training modules for bank loan officers on the risk profile of the private for profit health sector. | | Month 12 | | | | |
| | 2.3 Conduct a strategic communications campaign throughout the regions to promote private health sector financing among financial institutions. | | Month 13–15 | | | | |
| | 2.4 Monitor and evaluate utilization of the portfolio loan guarantee program to ascertain feasibility and likelihood for success for roll-out into all regions of Uganda. | | Month 6–24 | | | | |
| **3.0 Financial products are limited in breadth and depth in part due to legal and regulatory burdens.** | **3.0 Increase access to financial services and insurance products through regulatory reform and market-based incentives programs.** | 3.0 Increased breadth and depth of financial services accessible for private health sector. | 36 months total | High | Medium | Medium | High |
| | 3.1 Provide support to the GOU to provide inputs on the draft leasing law to provide more clarity in leasing relationships. Engage health stakeholders to advocate on behalf of the Leasing law under consideration in the Parliament | | Month 1–12 | | | | |
| | 3.2 Work with the Credit Reference Bureau and Bank of Uganda to consider formal access to the Credit Reference Bureau to mitigate risk and enhance opportunities for private sector finance. | | Month 1–15 | | | | |
| | 3.3 Investigate the feasibility of a subsidy program for the Credit Reference Bureau to subsidize microfinance institution access to credit history, tied to a commitment for the microfinance institution to provide targeted microloans to the private health sector. | | Month 1–3 | | | | |
| | 3.4 Monitor existing mobile payments pilot program; provide discrete advice as needed. | | Month 1–6 | | | | |
| | 3.5 Compile and distribute best practices in mobile payments legal and regulatory schemes among stakeholders. | | Month 6–9 | | | | |

## ACCESSING FINANCE (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 3.6 Provide support as requested for drafting for a law on mobile payments. | | Month 9–16 | | | | |
| | 3.7 Build capacity within, and connect private health advocacy organizations with mobile payment operators to enable stakeholder advocacy for health financing options | | Month 16–36 | | | | |
| **4.0 Health insurance penetration remains very low for the market in Uganda, and remains out of reach for the poorest, and also for the most rural Ugandans.** | **4.0 Collaborate with GOU, local governments, donors, and insurance industry to develop new approaches toward community health finance (CHF) programs in Uganda.** | 4.0 Increased penetration of private voluntary health insurance throughout Uganda. | 36 months total | Medium | Medium | Medium | High |
| | 4.1 Engage in dialogue with the MoH, DHOs, donors, and the private sector engaged in the CHF sector to identify best practices and lessons learned in the Ugandan CHF sector. | | Month 1–6 | | | | |
| | 4.2 Gather stakeholders for a conference to establish strategic development guidelines for the CHF sector. | | Month 3 | | | | |
| | 4.3 Conduct a needs assessment of existing CHF schemes to ascertain key concerns limiting expansion | | Month 3–6 | | | | |
| | 4.4 Provide technical assistance in developing streamlined administrative processes, basic financial accounting, and product development processes at the CHF level. | | Month 6–18 | | | | |
| | 4.5 Work with the UIC to develop simple regulations to help establish formal recognition of the CHF sector. | | Month 6–18 | | | | |
| | 4.6 Identify innovative technologies, such as new mobile networking technologies, that could be developed through organizations already working with mobile providers to facilitate organizing CHFs into a Community of Practice, as well as potential linkages through mobile payments technology to pool funds between formal CHF schemes. | | Month 12–24 | | | | |
| | 4.7 Engage potential reinsurnace companies to identify possibilities for insuring an integrated CHF scheme. | | Month 12–24 | | | | |
| | 4.8 Work with private insurance industry to expand upon private sector participation in micro-insurance, and identify potential for public-private partnerships to the CHF sector in rural communities. | | Month 24–36 | | | | |
| **5.0 Limited access to finance for PFP and PNFP clinics and medical service providers restricts rapid scale-up of well-run, well-managed companies.** | **5.0 Investigate opportunities for private health sector franchising as an alternative mechanism for private sector financing while achieving scaled quality health services.** | 5.0 Increased investment in health sector, increased quality control mechanisms in health sector, and an increased number of health service providers. | 24 months total | Medium | High | High | High |
| | 5.1 Conduct an analysis of the intellectual property rights regime to identify current enforcement gaps. | | Month 1–3 | | | | |
| | 5.2 Conduct due diligence on existing PFP and PNFP organizations to ascertain potential "pilot" options for health services. | | Month 1–6 | | | | |

## ACCESSING FINANCE (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 5.3 Conduct market analysis to ascertain sub-sector services with low market penetration for increased likelihood for pilot success. | | Month 1–6 | | | | |
| | 5.4 Coordinate with economic growth and legal reform activities to strengthen intellectual property rights. | | Month 3–15 | | | | |
| | 5.5 Consider organizing a study trip of potential franchisors to Kenya to connect with successful health franchise entrepreneurs. | | Month 12 | | | | |
| | 5.6 Work with local law firms and international expert to develop franchise contracts with pilot organization to carefully arrange terms and enforcement options. | | Month 3–15 | | | | |
| | 5.7 Support advertising of health franchising opportunities through associations. | | Month 6–24 | | | | |
| | 5.8 Capture data on best practices of franchise pilot program for reporting to other franchise candidates, financial institutions, government, and donors. | | Month 16–18 | | | | |
| | 5.9 Based upon outcome of franchising pilot, identify whether addition legal reforms are necessary to enhance the enabling environment for franchises. | | Month 18–24 | | | | |

## PROVIDING AND MAINTAINING FACILITIES

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| **1.0 There is a critical need for medical equipment in health care facilities, especially for sophisticated equipment in hospitals.** | **1.0 Collaborate with financial service providers and stakeholders to identify options to secure financing for medical equipment.** | 1.0 Increased breadth of financial products available to the private health sector for equipment and devices. | 24 months total | Medium | High | Medium | Medium |
| | 1.1 Work with lending institutions to provide affordable loans to hospitals. | | Month 1–9 | | | | |
| | 1.2 Identify opportunities for public/private partnerships to establish government guarantees for certain types of critical equipment. | | Month 1–24 | | | | |
| | 1.3 Provide assistance in developing specialized funds within health service providers to account for equipment maintenance throughout the functional life of the equipment. | | Month 6–24 | | | | |

## PROVIDING AND MAINTAINING FACILITIES (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| **2.0 The legal framework and implementing institutions do not create a proper incentive to encourage continued investment into health facilities** | **2.0 Support legal reforms and enforcement of laws to incentivize investment into existing and new health facilities.** | 2.0 Increased foreign direct investment and domestic investment in private health facilities due to reduced barriers to market entry and excessive regulatory burden. | 36 months total | High | Medium | High | High |
| | 2.1 Engage with stakeholders and the GOU to authorize facility registration in the name of any owner, removing restrictions of registration for medically trained owners. | | Month 1–12 | | | | |
| | 2.2 Conduct a study of the existing investment promotion benefits and tax burdens to identify opportunities to incentivize capital investments in health facilities. | | Month 1–6 | | | | |
| | 2.3 Present upon the investment promotion policy review aimed at the Uganda Investment Authority and Ministry of Health to commence a dialogue for an investment promotion policy within the health sector that fits within the health policy framework. | | Month 6 | | | | |
| | 2.4 Support the GOU in a regulatory "guilliotine" process to provide a framework for dialogue among stakeholders to help identify overlapping or overly burdensome regulations for health company startup, facility startup and operations. | | Month 12–18 | | | | |
| | 2.5 If national review deemed effective, expand regulatory "guilliotine" process to policies of local governments outside of urban zones to establish a process for municipal review of regulatory burdens to health sector business startup, facility startup and operations. | | Month 18–36 | | | | |

## GOVERNING THE SYSTEM

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| **1.0 The contribution of private for profit contributors is not documented nor appreciated as it pertains to the overall health system.** | **1.0 Provide incentives and fund system refinement for the private sector to provide data, potentially by coupling with the recertification process or by establishing service level agreements with private entities to provide primary care** | 1.0 Private for profit sector will have additional political capital for policy advocacy by demonstrating their impact on national health outcomes | 12 months total | High | Medium | Medium | High |
| | 1.1 Determine how government mechanisms, such as the HMIS can be modified to include the contributions of the private sector | 1.1 Data reporting practices will strengthen management skills of the private for profit sector, making them more attractive investments for private loan providers | Month 1–6 | | | | |

## GOVERNING THE SYSTEM (CONT.)

| Challenge | Recommendations | Anticipated Outcome | Timeline | Estimated Return on Investment | Feasibility | Likelihood for Success | Likelihood for Transformative Change |
|---|---|---|---|---|---|---|---|
| | 1.2 Develop an incentive structure that provides a benefit to private health providers so that they are compelled to engage in data reporting | | Month 1–6 | | | | |
| | 1.3 Design instructional materials and roll-out plan to train private for profit providers | | Month 7–10 | | | | |
| | 1.4 Include feedback in the health performance report | | Dependent on timing with regards to reporting cycle | | | | |
| | 1.5 Recertification process for private clinics will depend on record of data reporting | | Month 12 | | | | |
| | 1.6 Service level agreements may make the private for profit participants eligible for additional sources of funding | | Month 12 | | | | |
| **2.0 Supporting systems are weak, with no single entity garnering enough influence to enforce the governmental system of governance nor to enforce their own** | **2.0 Support the creation of, or strengthen an existing umbrella organization for all private medical practitioners to ensure their participation in policy and budget formulation, as well as self-regulation** | 2.0 Through the association, the needs of private providers can be represented in policy and governmental forums, resulting in more favorable policies for their interests. | 24 months total | Medium | High | Medium | Medium |
| | 2.1 Identify 1–3 associations with the greatest potential to advocate effectively for required changes in private health; develop and offer skills trainings for members, assist in developing medical-business plans | 2.1 Quality standards can be enforced through this entity for private practitioners and facilities | Month 1–2 | | | | |
| | 2.2 Poll private providers to determine the services and support services that would be sought in a professional association | | Month 1–4 | | | | |
| | 2.3 Provide assistance to develop membership fees and alternate sources of finance to reduce or eliminate dependence upon public or donor sources to improve sustainability. | | Month 5–10 | | | | |
| | 2.4 Work with the associations to build their advocacy abilities and their abilities to reach members of the Government, Parliament, the press, etc, to enable them to advocate and publicize their efforts | | Month 5–10 | | | | |
| | 2.5 Work with the associations to assist them to roll-out a first phase of skills training and development to members for fees. | | Month 11–15 | | | | |
| | 2.6 Launch a membership campaign to enroll private providers in the association | | Month 15–20 | | | | |
| | 2.7 Support associations in working with commercial banks and other financial institutions to provide updates on industry developments to develop industry specialization within financial service providers. | | Month 20–24 | | | | |

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