



EXPLORING PARTNERSHIP OPPORTUNITIES TO ACHIEVE UNIVERSAL HEALTH ACCESS

2016 UGANDA PRIVATE SECTOR ASSESSMENT IN HEALTH



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ACRONYMS

ACGR	Average Compounded Growth Rate
ACP	AIDS Control Program
ACT	Artemisinin-based Combination Treatment
AHPC	Allied Health Professionals Council
AHSPR	Annual Health Sector Performance Report
AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ANC	Ante-natal Care
APSPR	Annual Pharmaceutical Sector Performance Report
ART	Anti-retroviral Therapy
ARV	Anti-retroviral (drugs)
ASCAs	Accumulated Savings and Credit Associations
BDC	Becton, Dickinson, and Company
BoU	Bank of Uganda
BTC	Belgian Technical Cooperation
CBHI	Community-based Health Insurance
CBO	Community-based Organization
CDC	Centers for Disease Control
CHAI	Clinton Health Access Initiative
CMS	Central Medical Stores
CPD	Continuous Professional Development
CPHL	Central Public Health Laboratories
CSO	Civil Society Organization
DCA	Development Credit Authority
DHIS	District Health Information System
DHIS 2	District Health Information System (Version 2)
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic Health Survey
DRGs	Diagnosis-Related Groups
EAC	East African Community
EAPHLNP	East African Public Health Laboratory Networking Project
ECSA	East, Central and Southern Africa
EMHS	Essential Medicines and Health Supplies
EMTCT	Elimination of Mother-to-Child Transmission (of HIV)
ESD	Epidemiological Surveillance Division
FBO	Faith-based Organization
FUE	Federation of Uganda Employers

GAVI	Global Alliance Vaccine Initiative
GDP	Gross Domestic Product
GFF	Global Financing Facility
GFTAM	Global Fund for TB, AIDS, and Malaria
GOU	Government of Uganda
GPP	Good pharmacy practice
HC	Health Center
HCT	HIV Counseling and Testing
HEPS	Coalition for Health Promotion and Social Development
HFS	Health Financing Strategy
HIV	Human Immunodeficiency Virus
HPAC	Health Policy Advisory Committee
HR	Human Resource (s)
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSA	Health System Assessment
HSD	Health Sub-District
HSDP	Health Sector Development Plan
HSSIP	Health Sector Strategic and Investment Plan
HSSP	Health Sector Strategic Plan
HTI	Health Training Institute
ICRU	Inter-religious Council of Uganda
IRA	Insurance Regulatory Authority
JMS	Joint Medical Stores
KPA	Kenya Pharmaceutical Association
Lab	Laboratory
LMIC	Low and middle-income countries
MAUL	Medical Access Uganda Limited
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MDI	Microfinance Deposit-taking Institution
MESTS	Ministry of Education, Science Technology and Sports
MFI	Microfinance Institution
MMR	Maternal Mortality Ratio
MoEPED	Ministry of Finance Planning and Economic Development
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoLG	Ministry of Local Government
MOU	Memorandum of Understanding

MSME	Micro, small and medium-size enterprise
NARO	National Agricultural Research Organization
NASA	National AIDS Spending Assessment
NDA	National Drug Authority
NDC	National Disease Control
NDP	National Development Plan
NGO	Non-Government Organization
NHA	National Health Accounts
NHIS	(Uganda) National Health Insurance Scheme
NHLSP	National Health Laboratory Services Policy
NHLSSP	National Health Laboratory Services Strategic Plan
NHP	National Health Policy
NMP	National Medicines Policy
NMS	National Medical Stores
NPP	National Population Policy
NPSSP	National Pharmaceutical Sector Strategic Plan
NRHL	National Referral Hospital Laboratories
NTRL	National TB Reference Laboratory
ODA	Overseas Development Assistance
OECD	Organization for Economic Cooperation and Development
OOP	Out-of-pocket
OTC	Over-the-counter
PBF	Performance-based Financing
PEAP	National Poverty Eradication Action Plan
PEPFAR	The (US) President's Emergency Plan for AIDS Relief
PFP	Private-for-Profit
PHC	Primary Health Care
PHP	Private Health Provider
PHS	Private Health Sector Support Program
PMI	(US) President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child (HIV) Transmission
PNFP	Private-not-for-Profit
POA	Policy Options Analysis (for Uganda's Pharmaceutical Supply System)
PPD	Public-Private Dialogue
PPP	Public-Private Partnership
PPPH	Public-Private Partnership for Health
PSA	Private Sector Assessment
PSD	Public Sector Dialogue
PSE	Private Sector Engagement
PSU	Pharmaceutical Society of Uganda

QI	Quality Improvement
RBF	Results-based Financing
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
ROSCAs	Rotating Savings and Credit Associations
SACCOs	Savings and Credit Cooperative Organizations
SDG	Sustainable Development Goals
SIDA	Swedish International Development Cooperation
SLMTA	Strengthening Laboratory Management Towards Accreditation
SMC	Safe Male Circumcision
SME	Small and medium-size enterprises
SMP	Safe Motherhood Program
SQIS	Self-regulatory Quality Improvement System
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
SURE	Securing Ugandans' Rights to Essential Medicines (Project)
SWAp	Sector-wide approaches
TA	Technical Assistance
TB	Tuberculosis
TCMP	Traditional and Complimentary Medicine Practitioners
THE	Total Health Expenditure
TM	Traditional Medicine
TPAs	Third Party Administrators
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBTS	Uganda Blood Transfusion Services
UCBHFA	Uganda Community Based Health Financing Association
UCMB	Uganda Catholic Medical Bureau
UDHS	Uganda Demographic Health Survey
UHA	Uganda Healthcare Federation
UHC	Universal Health Coverage
UHF	Uganda Healthcare Federation
UMA	Uganda Medical Association
UMHCP	Uganda Minimum Health Care Package
UMMB	Uganda Muslim Medical Bureau
UN	United Nations
UNCHO	Uganda National Health Consumers Organization
UNHCMP	Uganda National Minimum Health Care Package
UNIDO	United Nations Industrial Development Organization
UOMB	Uganda Orthodox Medical Bureau

UPMA	Uganda Private Midwives Association
UPMB	Uganda Protestant Medical Bureau
UPMPA	Uganda Private Medical Practitioners Association
USAID	United States Agency for International Development
USG	United States Government
UVRI	Uganda Virus Research Institute
VMA	Voucher Management Agency
VSLA	Village Savings and Loans Associations
WDI	World Development Indicators
WHO	World Health Organization

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DEFINITIONS

The definitions below are taken from the MoH's Public-Private Partnership in Health Policy (2012).

Access. The right, opportunity or ability to utilize a service or benefit from it.

Accountability. Being obliged and taking responsibility to give an explanation or justification for one's role, actions, outcomes, and use of resources to relevant authorities, beneficiaries and communities, and other stakeholders.

Accreditation. The action of accepting health facilities as having fulfilled required standards based on a set of accreditation criteria

Contract. A legally binding agreement stating clearly: the responsibilities of the parties to the contract, the range of services to be provided, the performance standards to be achieved, procedures for performance monitoring, terms of payment and penalties for non-performance

Civil Society Organizations. Non-governmental organizations contributing to delivery of health services, disease prevention, and control, mostly through community mobilization and capacity building.

Efficiency. The ability to produce satisfactory results with an economy of effort and minimum waste.

Identity. The unique mission, purpose, aims, principles, and values that make up an individual or organization, and the organization's right to claim recognition for achievements made.

Managerial Autonomy. Retaining the right to self-government and self-management of the organization's operations in line with organizational values and norms, while recognizing the need to make adjustments to meet commitments made in partnership agreements.

Memorandum of Understanding. A written reminder containing a record of agreed definitions, responsibilities, actions, and procedures for interaction between the partners.

Partner. One of two or more parties that have agreed to form a partnership.

Partnership. The *formal* relationship between two or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources and/or skills for the purpose of achieving these common goals.

Policy. A statement or a set of statements defining a desired direction of operations or actions that define the interests and values of people it is meant to serve. Statements are conceived to address a theme, or purpose of actions to society, institutions, and individuals, for present and future guidance.

Private. Not belonging to or run by either central or local government.

Private Sector in Health. The private health sector in Uganda, as Section 2 illustrates, is diverse, comprising both PFP organizations (commercial, self-sustaining) and PNFP organizations (faith-based, non-governmental, or community-based).

Private Sector Engagement. Public-private engagement is comprised of three related processes; public-private dialogue as a first phase and interactions as a second phase, leading to a full operational partnership as the summative phase.

Public. Central, district or local government.

Public-Private Partnerships. Public-Private Partnerships are the most complex and difficult form of private sector engagement. In Uganda, the term PPP describes a spectrum of possible relationships between the public and private actors for integrated policy dialogue, planning, provision and monitoring of services widely defined as not only clinical services but also other activities performed in the health sector (e.g. production of human resources in health, supply chain of health goods and medicines). The essential prerequisite is some degree of private participation as well as transfer of risk to the private sector in the delivery of traditionally public domain services.

Sustainability. Ability to withstand economic, social and political problems during the course of the years.

Umbrella Organization. Coordination structure established at national level, with the function to represent, coordinate, provide support services and accredit their members. It does not have authority over the individual members.

Technical Working Group on Public-Private Partnership in Health. A Health Sector Working Group appointed by the Health Policy Implementation Committee (HPIC), now Health Policy Advisory Committee (HPAC), to advance the contribution of the Private Health Sector to the implementation of the Health Sector Strategic Plan.

Private Health Providers. In the context of this report, private health providers (PHPs) are synonymous with private-for-profit (PFP) health providers. The MoH defines PHPs as all cadres of the health profession in Clinical, Dental, Diagnostics, Medical, Midwifery, Nursing, Pharmacy, and Public Health disciplines who provide health services outside Government and PNFP establishments.

EXECUTIVE SUMMARY

The Ministry of Health (MoH), with support from the United States Agency for International Development (USAID) and the World Bank Group’s Health in Africa Initiative (HIA) and the Global Financing Facility (GFF), commissioned an assessment of the private health sector in Uganda (PSA). The USAID/Uganda Private Health Support Program assisted the MoH to carry out the PSA. The PSA aims to generate and consolidate data on private sector activities into a single document to better understand the relevance of the private sector in the Ugandan health system. An appreciation of the private health sector’s size and scope will guide MoH policy and planning and donor programming to better harness all resources – public and private alike – to help Uganda achieve Universal Health Coverage (UHC).

The objectives of the assessment are:

- To document and develop a comprehensive understanding of private sector activities throughout the health system in Uganda
- To identify potential areas for the Ugandan private health sector to contribute to MoH’s goal and objectives as outlined in Health Sector Development Plan (HSDP) 2015/16-2019/20.
- To propose a road map to harness private sector potential to address a select number of strategic health service areas and/or systems gaps as outlined in the MoH Public-Private-Partnership Policy and Strategy.

1. METHODOLOGY

The PSA team adapted USAID’s approach of “Assessment to Action”, emphasizing stakeholder collaboration and engagement.



Plan: The MoH formed a Technical Advisory Committee composed of public and private stakeholders to shape the PSA’s scope and guide its implementation. The Commissioner of Health Services/Planning chaired the Committee and led the consultative process to validate the PSA.

Learn: The PSA Team conducted a literature review and stakeholder interviews. The team met with a diverse range of public and private organizations and individuals, located in both urban and rural areas, and interviewed a total of 173 stakeholders.

Analyze: The PSA team triangulated from data from the literature review, secondary data analysis of existing data sets, and stakeholder interviews and organized the findings according to the World Health Organization’s (WHO) health system building blocks.

Share: The Advisory Committee played an active role in reviewing and commenting on the 1st draft and disseminated the initial findings to public and private stakeholders. They also helped develop a strategy - *Private Sector Blue Print* – to harness the private health sector.

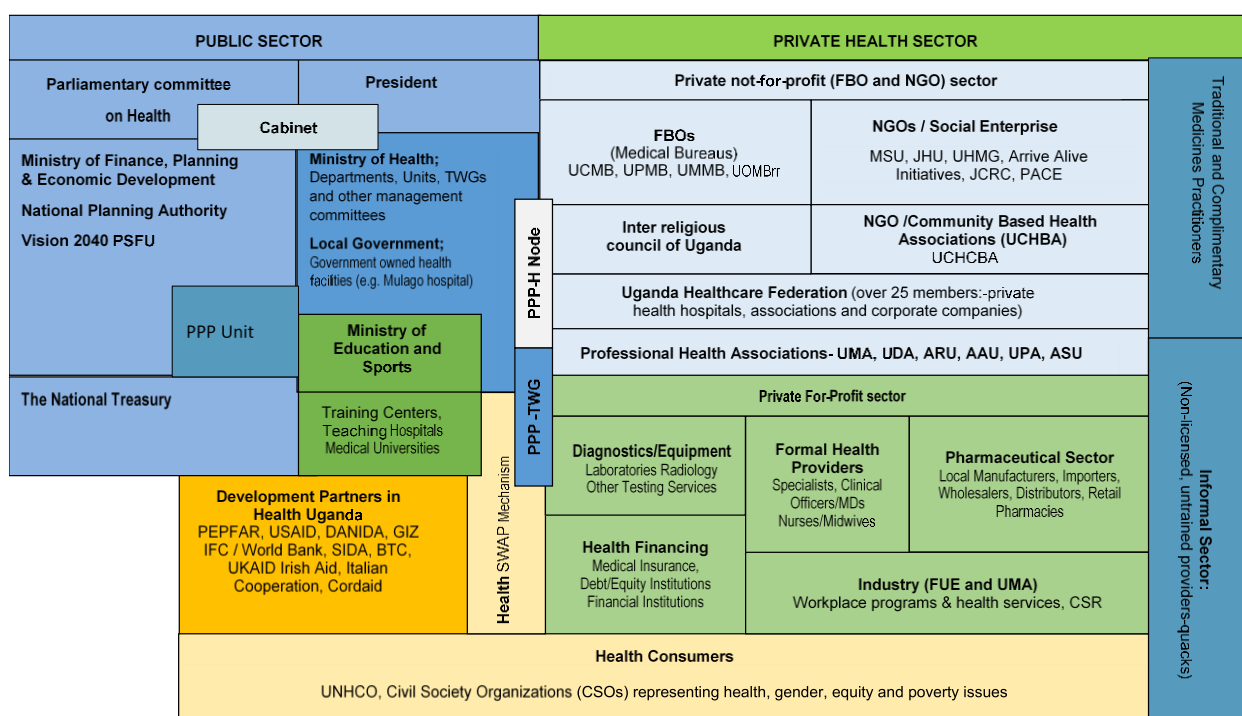
Act: The MoH convened a meeting in May 2016 to officially launch the PSA and to repurpose the PPPH TWG to steward the PSA’s recommendations and to monitor implementation of *Private Sector Blue Print*. Subsequently, the PSA was validated with participants from 40 districts.

2. OVERVIEW OF THE UGANDA HEALTH SYSTEM

2.1. Landscape of the Health System

Traditionally, most health sector assessments as well as government produced health policies and plans, focus primarily on government organizations and the public health delivery systems. An important product of the PSA is to landscape (see below) all the public and private actors to offer a comprehensive illustration of the principal groups operating in *a mixed delivery health system*. The Ugandan health system is organized into six segments of health stakeholders: (i) government sector, ii) Development Partners and their implementing agencies, iii) private-not-for-profit (PNFP), iv) private-for-profit (PFP), v) civil society, and vi) informal health sector including Traditional and Complementary Medicine Practitioners and un-licensed private practitioners. Although not exhaustive, the landscape illustrates the complexity and challenges the MoH confronts in its lead role as a steward of the *entire* health sector.

The landscape highlights several points about the Ugandan health sector:



- Government operations in health include more than just the MoH, particularly with the push to decentralize health decision-making and service delivery to the district levels;
- The private health sector is diverse and still somewhat fragmented, despite evidence that the first point of contact for health service demand is largely in the private sector;
- Civil society has yet to find its voice to represent the consumer perspective on health;
- Development Partners play an instrumental role, both in terms of resources and technical assistance; and
- The informal health sector operates mostly outside of the law.
- Public sector health workers also operate in the private sector
- Policy and regulatory inconsistencies limit active private sector participation in the health system
- Little has been documented on the large and diverse traditional and complimentary medicine sub-sector

It is important to have a common definition of the private health sector to interpret the PSA findings. For the purposes of the PSA report, private sector includes both formal and informal, PNFP and PFP. Moreover, the private sector includes a wide range of private entities in different aspects of the health system such as pharma, financing, etc. (see diagram).



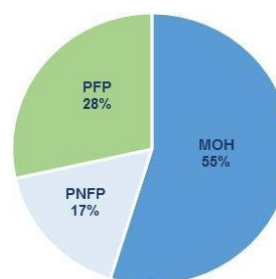
2.2. Numbers Describing the Health Delivery System

Public-Private Mix (PPM) of Health Facilities. According to the MoH, the total number of health facilities almost doubled between the years 2005 to 2012 from 2,731 to 5,229.

All three sectors (public, PNFP and PFP) experienced growth in the number of health facilities: public facilities grew by 50%, PNFP grew by 45%, and PFP increased by 500% (from 277 to 1,488). Although there was growth in all facility levels, the most dramatic growth occurred in Health Center (HC) II and III.

MoH's 2012 Health Facility Inventory shows there are approximately 5,229 health facilities in Uganda. The public sector owns more than half (55%) while the private sector – PNFP and PFP – own and manage 45% of all health facilities (see figure). PFPs own more facilities than the PNFP - 28% and 17%, respectively.

% of Health Facilities by Ownership,



Source: Uganda Health Facility Inventory, 2012

Distribution of Public-Private Health Facilities. Despite the dramatic growth in health facilities, distribution of and access to a health facility is not equitable. Given the distribution of health facilities, there is room to better coordinate and rationalize health service delivery across public and private providers.

- Almost 1/3 of Uganda's health facilities are in the greater Kampala metropolitan area.
- The poorest regions - Karamoja, West Nile and the North - have the least number of health facilities.
- The 2,867 public facilities are concentrated in South West, Eastern and the North Regions.
- The 848 PNFP facilities are in South West, Central 1 and Eastern with considerable overlap with MoH facilities in the same regions.
- Almost all of the 1,488 PFP facilities are concentrated in Kampala where there is a limited number of public and PNFP facilities.

Public-Private Mix of Human Resources in Health (HRH). The PSA Team found inconsistencies and irregularities in health workforce data for the following reasons: i) the MoH collects little or no standardized data on private health providers (PHP); ii) HRH data is fragmented and located in different MoH departments; and iii) there is double counting due to dual practice. The HRH numbers are best estimates.

About half (47%) of the health workforce are employed in a private (both PHP and PNFP) facility. Most doctors (80%) work in the private sector including general practitioners and specialists. Similarly, most allied health providers work in the private sector - clinical officers (60%), pharmacists (93%) and dispensers (69%). In contrast, a lower percentage of nurses (43%) and midwives (17%) are employed in the private sector. There is significant percentage of health cadres in dual practice; for example, more than half (54%) of the physicians in Uganda work in both the public and private sectors.

Select Health Cadres by Workplace

HRH Category	Total	Public	PNFP	PHP	Private Sector %
Doctors	5,141	1,047	361	3,733	80%
Nurses	28,885	16,490	4,145	8,250	43%
Midwives	12,115	10,465	987	663	17%
Clinical Officers	6,685	2,702	558	3,425	60%
Laboratory staff	8,926	2,447	746	5,733	73%
Pharmacists	657	45	24	588	93%
Dispensers	551	169	172	210	69%
Total Available	67,237	35,248	7,522	24,467	47%

Sources: Adapted from MoH HRH Audit Report 2011, Professional Councils' databases, PNFP websites

The significant number of HRH working in the private health sector underscores the need to standardize data collection on HRH, and to better plan and coordinate HRH across the public and private sectors.

Public-Private Mix of Health Training Institutions (HTIs). Uganda, like many other low- and middle-income countries, is grappling with shortages in the health workforce. The role of the private sector regarding health training institutions (HTIs) cannot be down played: both PNFP and PHPs together own 72% of *all* HTIs. The private sector is the biggest operator of nurse/midwifery schools in Uganda: of the 79 nursing/midwifery HTIs, the MoH owns 18% compared to the PNFP (33%) and PFP (49%). The private sector owns 63% of all Allied HTIs compared to the public sector (37%). One out of the five university medical schools is a PHP institution. Stakeholder interviews revealed that coordination between the HTIs by the respective Ministries would help the country produce the number and types of HRH urgently needed.

2.3. Key Findings

The private health in Uganda sector:

- Is active in *all* the WHO health system building blocks, not just health service delivery;
- owns and operates a significant percent of health infrastructure;
- employs most doctors, pharmacists and laboratory pathologists;
- trains an important number of health professionals; and
- Is located throughout Uganda, particularly the PNFPs in rural areas and PHPS in urban areas.
- Has no standardized service pricing guidelines
- Is sub-optimally regulated
- Receives very limited support from the public sector
- Has no guiding market analysis to select bankable health sector investments
- Sub-optimal coordination of the private sector

The private sector desires a greater role in contributing to the health and well-being of Ugandans. The GoU will miss an important opportunity to harness private sector resources if they do not act now. But the private sector – particularly PHPs – will need to get organized into professional associations, service delivery networks, etc. to facilitate greater cooperation.

3. ENABLING ENVIRONMENT SUPPORTING A PRIVATE SECTOR ROLE IN UHC

3.1. Policy Framework

Overall, the policy environment is conducive for a private sector role in the Ugandan health system, despite a significant incidence of policy and regulatory inconsistencies. There has been a shift in government's attitude in work with the PFP sector in the last ten years and the government of Uganda (GoU) has put in place the policy framework and institutional arrangements needed to engage non-state health actors. In fact, Uganda is one of the first Sub-Saharan African countries to formulate a Public-Private Partnership in Health (PPPH) Policy and draft implementation guidelines.

- The PPPH Policy is a major step forward but requires more awareness. The policy is widely known among government sector, PNFPs and PHPs at the national level, but there is little awareness outside of Kampala.
- The absence of a common language on PPPHs, and a strategy detailing PPPH priority areas and mechanisms will continue to be a barrier to implementation.
- Political commitment to PPPHs varies, with pockets of resistance to working with PHPs. Support for working PHPs also varies among Development Partners.
- The PPPH Node has a big mandate but no direct budget to fund the Node's staff and activities. The Node is understaffed and acknowledge a gap in some competencies, such as financing, contract law, dialogue, contract management, and conflict resolution.
- There is no policy and regulatory framework that guides dual practice, despite the finding that public sector workers are all active in the private sector
- There are no service pricing guidelines for the private sector
- There is very limited health insurance presence that could support private sector participation in health

Governance and regulations of the private sector is another challenge. There are multiple agencies responsible for private sector quality that have similar, overlapping functions. The roles and responsibilities between the various agencies are not clear and is further compounded by little coordination between them. Moreover, the multiple government agencies have different standards to measure quality and often request the same information from a PHP, making compliance cumbersome and costly. Enforcement is also weak because the Councils do not have sufficient staff and the mandate to shut down unscrupulous providers and adequate resources to visit and supervise all private providers.

Also, the MoH have a need of many essential "tools of government" and critical systems to regulate and supervise the private health sector, such as: i) up-to-date and accurate data on all healthcare providers, particularly PHPs; ii) Inclusive policy and planning processes involving all stakeholders – including PHPs – perspectives; iii) a unified, streamlined and responsive professional licensing system; and iv) a standardized, streamlined facility licensing and inspection system.

However, the PSA noted several MoH initiatives underway to address these gaps. They focus on i) unifying and streamlining a quality process overseeing the private sector (see text box), ii) simplifying professional licensing and continuing professional development hours and iii) modernizing facility inspections and licensing.

Promising Approach to Quality Assurance in the Private Sector

The MoH QA Department, all four councils, KCCA and private provider associations worked together to develop a self-administered tool – Self-Regulatory Quality Improvement System (SQIS) – to assess quality in private sector facilities. The councils manage the SQIS and have rolled out this simple tool to over 300 private facilities.

3.2. Public-Private Relations

Old mindset on public-private collaboration persist. On the private side, i) PNFPs feel they are treated as an extension of the MoH and not as an autonomous and equal partner; ii) PHPs feel under-appreciated and isolated from the rest of the health sector; and iii) PHPs are frustrated that they cannot access subsidies and exemptions when offering health services to the poor. On the public side, some MoHs officials: i) believe all health services should be free; ii) complain about PHPs' quality yet do not have the data substantiate these claims; iii) do not trust PHPs because of under-reporting; iv) assumes PHPs are only concerned about profit-making; and iv) tend to trust PNFPs more than PHPs.

PHPs are largely absent from governance processes and policy forums. At the national level, the Ugandan MoH established several governance structures and forums to foster dialogue and coordination. The PNFPs participate in all the relevant forums given their long-standing working relationship with the MoH. The PHPs, however, are largely absent at these forums. Despite these conditions, the PHPs consider partnerships important, aspire to more involvement in policy and planning. PHPs interviewed want to find an *immediate* way forward to build a relationship with the MoH.

The PNFPs, on the other hand, want to continue their productive working relationship with the MoH but want a *different* form of partnership, such as service contracts and national health insurance.

3.3. Market Conditions and Access to Finance

Market Conditions. Stakeholders described difficult market conditions, particularly for individual private practitioners, who struggle to eke out a living as a health business. Barriers to market entry are too low mainly due to poor enforcement of quality standards and regulations. As a result, there is an increasing number of “quacks” in the health system. The crowded market drives prices down even though the cost of inputs is high, particularly for staff and medicines. The absence of pricing guidelines from regulators further compounds this problem. Finally, a big segment of the population cannot afford to pay the appropriate prices for the services, making it difficult for PHP to recuperate their costs.

Health care facilities face many of the same constraints as do other small and medium-sized businesses in Uganda. PHPs businesses recognize they need training in general business and financial management as well as technical assistance to establish accounting and quality systems to register with a private health insurance. Like most small business, PHPs also experience cash flow constraints that limit their ability to invest in quality improvements and/or expand services. Finally, many private healthcare businesses cannot meet the terms of loans offered by financial institutions, such as security collateral requirements and high interest rates, prompting many clinic owners to borrow as individuals or to ask family members to invest.

Access to Finance. Access to finance is a major constraint for the private health sector to prosper as an industry. The limited public sector subsidy to mainly PNFPs covers a minute proportion of private sector service costs. On the demand side, a 2015 survey of PHPs found that only 16% of health businesses borrowed from a bank for business purposes. The PSA also revealed that PNFPs likewise need capital to upgrade their hospitals and purchase equipment but are ineligible because they are a not-for-profit entity. The potential for commercial lending to the health sector is great; one estimates a potential \$427 million for short- and long-term borrowing in health, making it a significant market opportunity for Uganda's commercial banks and microfinance institutions. While the numbers show a positive trend in health sector lending, the value (UGX 22.4 billion-USD 6.7 million) represents only 1% of Uganda's commercial bank total loan portfolios. The main challenges facing the financial institutions and hindering lending to the private health sector are: i) inflation poses a threat to lending to the private sector; ii) perceived risk in lending to health organizations that are predominantly sole proprietor businesses; iii) poor business management skills of health business owners; and iv) lack of collaterals in loan applications.

3.4. Key Findings

From a private sector perspective:

- The PPPH Policy is a major step forward, but the policy is at a critical juncture. As the stakeholder interviews revealed, the private sector is keen to work more closely with the MoH. The MoH, however, may risk momentum with the private sector because of government inaction and weak political support.
- The policy and regulatory inconsistencies in the market must be addressed. These include policies that seem to contradict each other, poor regulatory tools, lack of pricing guidelines, lack of dissemination of existing policies and regulations, to mention but a few.
- The MoH cannot effectively regulate the private sector without accurate data. All agree that the data on PHPs is not reliable because it is not standardized, not consistently collected and scattered across different MoH departments. Furthermore, PHPs under report to the MoH for a variety of reasons while the MoH does have good data on PNFP activities.
- Current policies and plans under-estimate private sector contribution. Most policies and plans focus on MoH and PNFPs activities, reflecting only half of all activities conducted in the Ugandan health sector. Moreover, key plans, like the current Five Year Strategy, mention PHPs as a “byline” but do not fully articulate what role PHPs can play or define strategies to leverage PHP infrastructure and resources.
- Private sector wants better regulation of quality because it affects their bottom line. Private providers want to comply with quality standards to earn consumer confidence in their health services. But the MoH’s fragmented approach to ensure quality sector allows for “quacks” to operate without impunity and for unscrupulous provider behavior.
- Private sector wants more frequent and regular communication with the MoH. Private sector leaders recognize that more interactions with the MoH is fundamental to building trust. They want to work together with the MoH to address key health system challenges while at the same time discuss strategies to improve market conditions.
- Private sector investments should be seen as synergizing Government efforts, and not as competing investments in the health system

3.5. Recommendations to Make the Environment More Supportive of a Private Sector Role

- **Build the “policy toolbox” to govern non-state actors external to the MoH.** The MoH has many initiatives underway to create the tools and systems needed to regulate and manage the private health sector, such as streamlining quality assurance systems and modernizing the professional and licensing registration and licensing systems. Data collection still remains a gap.
 - **Demonstrate MoH’s goodwill and commitment to partner with the private health sector, particularly PHPs.** Now is a window of opportunity to break through old mindsets. The private sector is looking to the MoH to demonstrate leadership and commitment by integrating private sector representatives in all policy forums; establishing establish a public-private dialogue mechanism; and, immediately brokering one to two PPPHs to assure the private sector that the MoH is serious about implementing the PPPH Policy.
 - **Invest in the PPPH Node’s capacity to fulfill its mandate.** The MoH can redouble its current support to the Node by: i) institutionalizing the PPPH Node; ii) investing in designing and building the Node’s operating systems and procedures; iii) supporting the Node to generate the data needed to regulate and monitor the private health sector; iv) tasking the Node to facilitate communicating and information sharing; and v) providing technical and financial resources so the Node can broker two partnerships soon. vi) enable the Node to support PPPH Desk officers in the districts to ably execute their intended roles

4. HEALTH FINANCING TO CREATE A SUSTAINABLE PRIVATE HEALTH SECTOR

4.1. Health Financing Trends

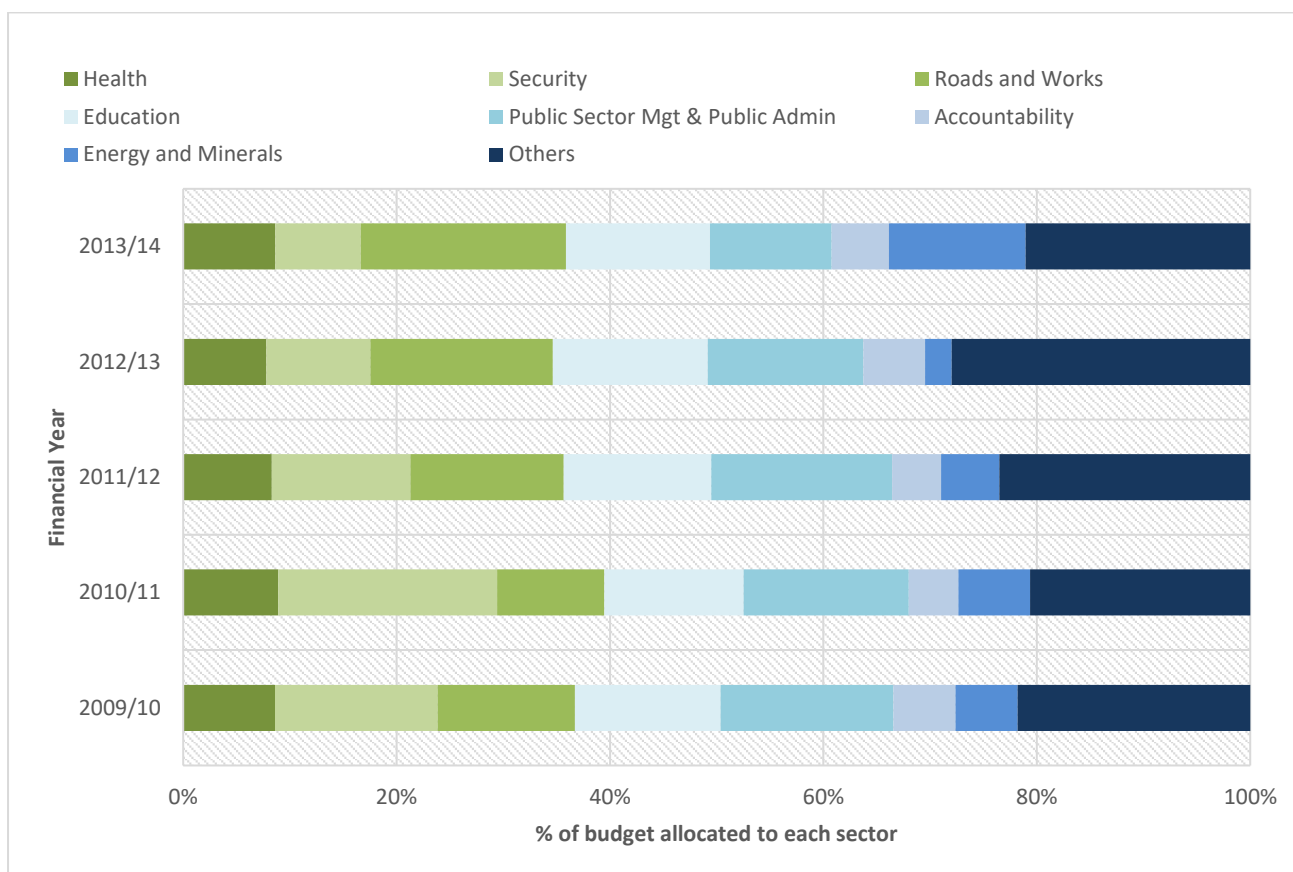
Health financing in Uganda presents a mixed picture. The Government has developed a Health Financing Strategy to guide resource mobilization, pooling and purchasing of Health Services. The principal mechanism of funding health services in Uganda is through government general revenue tax financing, however, out of pocket payments and contributions by Health Development Partners contribute a substantial amount of financing for health care services. Government allocation to the health sector has fluctuated over the last ten years between 7.2% to 9.0% of total government spending. Although this level is substantially lower than the Abuja target of 15%, it is higher compared to other SSA countries. Per capita expenditures on health has increased from USD \$21 in 2000/01 to USD \$52 in 2012/13. This increase, however, is still low by World Health Organizations (WHO) estimates that a developing country will need to spend USD \$60 per capita to deliver essential health services.

While the health budget has increased by 93 per cent over five years, (FY 2010/11-2015/16) from UGX 660 billion (FY 2010/11) to UGX1, 271 billion (2015/16), total government budget increased by 148 per cent from UGX 7,377 billion (FY 2010/11) to UGX 18,311 billion (FY 2015/16). It is important to note that the growth in the health budget has been mainly driven by increased external resources (e.g. the share of donor support to the health budget increased from 14 % (FY 2010/11) to 42 % (FY 2014/15).

Total health expenditures (THE) have risen dramatically since 2000, increasing six times from UGX 745 billion in 2000/01 to UGX 4,751 billion in 2011/12. Donor funds – particularly PEPFAR funds starting in 2006/07 – are responsible this increase.

During this period, donor funds grew seven-fold from UGX 305 billion to UGX 2,202 billion UGX. As result, donor contribution increased from 14% of THE in 2000 to 46% in 2012. Government contribution, on the other hand, declined over the same period from 18% to 15% of THE. Out-of-pocket (OOP) expenditures, the second most important source of health financing, has decreased negligibly from 40% in 2000 to its current level of 37%.

Proportion of the total budget allocated by sector (Includes on budget ODA)



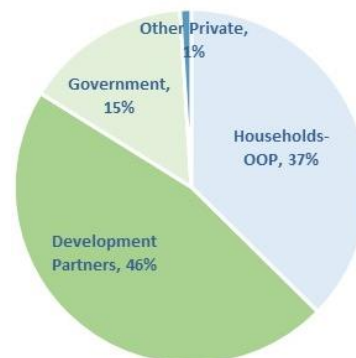
Source: MOFPED; Background to the Budget

4.2. Current Health Financing

The National Health Accounts (NHA) 2011/12 reports the distribution of THE by financing source (see figure). There is a heavy reliance on donor funds to finance health (46%) as well as household OOP (37%) while GoU contribution is currently at 15% of THE. Private health insurance's share remains small: 1%. Donor funds have enabled the GoU to reduce its share of THE.

According to the NHA 2011/12, most health funds (73%) were spent on out-patient curative services (45%), followed by in-patient curatives services (27%), and preventive services (17%). Despite the government's policy emphasizing preventive care, budget allocation to primary health care remains a low priority.

Health Expenditures by Financing



Source: NHA, 2011/12

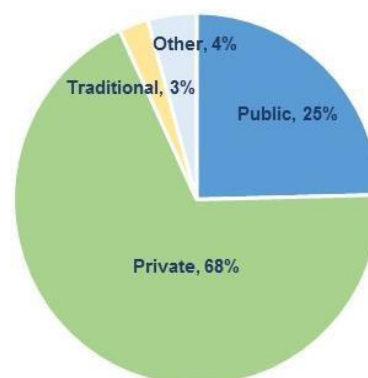
4.3. OOP Expenditures

Because government spending is not increasing to keep pace with population growth, households are forced to shoulder an increasing burden of financing healthcare. OOP spending is widely recognized an inequitable way to finance health, placing poor and lower income groups at risk of incurring catastrophic health-related expenditures. Uganda’s 37% OOP is almost double compared WHO’s recommendation to keep OOP at 20% to minimize catastrophic risk.

The NHA 2011/12 estimates OOP to be approximately USD \$23. More than 2/3 thirds (68%) of all OOP expenditures are spent in private facilities, which includes PFP drug stores, pharmacies, clinics and hospitals as well as PNFP facilities (see figure). Approximately ¼ (25%) of household OOP is spent in a public health facility which is a significant amount given the abolishment of user fees at public health facilities in 2001. Moreover, these households paying in a MoH facility come from the lowest income groups in Uganda.

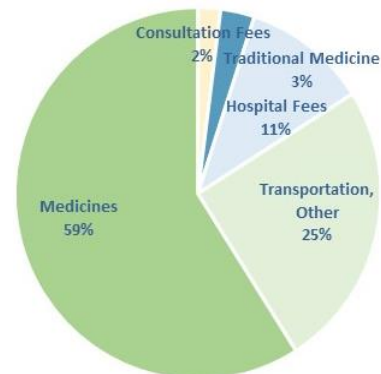
The clear majority (59%) of OOP is spent on drugs; a reflection of MoH challenges in medicine stock-outs and non-functional labs (see figure). It is interesting note that more funds are spent in getting to and from a public or private health facility (25%) than in consultation fees for a private consultation (2%).

OOP by Service Provider



Source: NHA 2011/12

OOP by Goods and Services



Source: NHA 2011/12

4.4. Status of Health Insurance

National Health Insurance. National health insurance is far from a reality in Uganda. There is a National Health Insurance (NHI) Bill pending in Parliament. The 2014 Bill seeks to mobilize finances for health by enrolling public and private employees as well as informal employees to pay premiums into a national scheme that ensures a defined health care package for all and subsidizes the cost of healthcare for poorest of the population. However, the PSA Team found that only 40% of formal sector employers had heard about the proposed NHI Bill, and those who had heard of it, were usually misinformed or unaware of its objectives.

Private Health Insurance. The private health insurance industry is small. Of the 20 plus licensed commercial insurance firms in the country, only 5 provide private health insurance. Few insurance companies offer health insurance, possibly due to the complexity of this type of insurance product. According to the private health insurance companies interviewed, the biggest obstacles facing growth of private health insurance industry, in this order, i) limited market, ii) overutilization of services, and iii) inaccurate recording practices by health providers. At an average cost of US \$200 per person insured, private health insurance is still prohibitive even for many corporate employers let alone individuals. There is a growing micro-insurance industry in Uganda, but only five of the 20+ licensed insurers offer micro-insurance with packages designed to target low-income and informal segments of the population.

Community Based Health Insurance (CBHI). CBHI has been in practice for over three decades in Uganda with most of the schemes based in the South West and Central Regions of the country. The schemes are mostly hospital-based and affiliated to a PNFP facility. CBHIs struggle to become a viable insurance mechanism: their premiums are too low, they do not have sufficient number of beneficiaries and they are not professionally managed.

The MoH acknowledges the importance of CBHIs, as demonstrated by their inclusion in the Health Financing Strategy 2016 and proposed NHI Bill but there are no provisions in either of these policies to fund CBHIs despite their focus on the poor.

4.5. Strategic Purchasing of Health Services

Primary Health Care (PHC) Conditional Grant. MoH's experience in purchasing health services is mostly through the PHC Conditional Grant mechanism. The MoH subsidizes FBO facilities in through delegated funds for recurrent non-wage activities health facilities and medical training schools. In 2003/04, the MoH also introduced a credit line allowing FBO hospitals and health centers to use credit to purchase medicines and supplies. In the last 10 years, there has been a steady decline in Grant amounts allocated to individual facilities due to stagnated GoU contributions to the Grant combined with an increasing number of FBO facilities. A Recent analysis shows that the Grant covers approximately 9% of a PNFP health facility's costs. The shortfall in GoU grant funds has forced the Bureaus to charge fees for goods and services which runs contrary to FBO's values. All Bureaus agree action is needed to address funding gaps but disagree on the solution. The Government withdrew PHC financial support to PHPs due to budgetary constraints.

Innovative Financing Mechanisms. More recently, the MoH is experimenting performance based financing (PBF) and maternal health vouchers. There is a nascent example of PBF in Uganda in partnership with the Uganda Catholic Medical Bureau. The PBF pilot is located in 5 districts in Eastern Uganda. The PBF pilot has demonstrated improvements in outpatient consultations (29% increase), antenatal care visits (67% increase) and facility deliveries (69% increase). As a result, PBF is a cornerstone of the Health Financing Strategy 2016.

The Government, in collaboration with the Belgian Technical Cooperation in Uganda has implemented a robust and successful PBF program in the West Nile and Rwenzori Regions of western Uganda, and the lessons are being applied to roll-out a wider PBF programme financed by the World Bank.

The World Bank and USAID Maternal and Reproductive Health (M/RH) voucher programs are implemented through partner organizations such as Marie Stopes, Baylor Uganda and Abt Associates. The World Bank program focuses on the Western and East Central regions while USAID's program is in the East and Northern Regions. A World Bank assessment revealed its program increased uptake of maternal health services by 9% and improved the quality of care delivered. As the M/RH voucher programs expand, they need to harmonize their approach to assure that they: i) cover the same M/RH benefits to avoid confusion among consumers; ii) do not duplicate resources; iii) have consistent provider reimbursement rates for comparable services; and iv) reduce management and administrative costs.

4.6. Key Findings

From a health systems perspective,

- Current funding levels are insufficient to achieve UHC according to WHO estimates. Gou contribution has stagnated in the last decade. Donor reliance on finance health is not sustainable, particularly if PEPFAR begins to withdraw support as they have in other middle-income SSA countries. And high OOP is inequitable making healthcare out of reach for the vast majority of Ugandans.
- Government, donors and households fund different health priorities. MoH funds focus on staffing for public administration and hospitals while donor funds finance curative, mostly HIV/AIDS services. Households, spend their OOP on medicines and diagnostics.

From a private sector perspective,

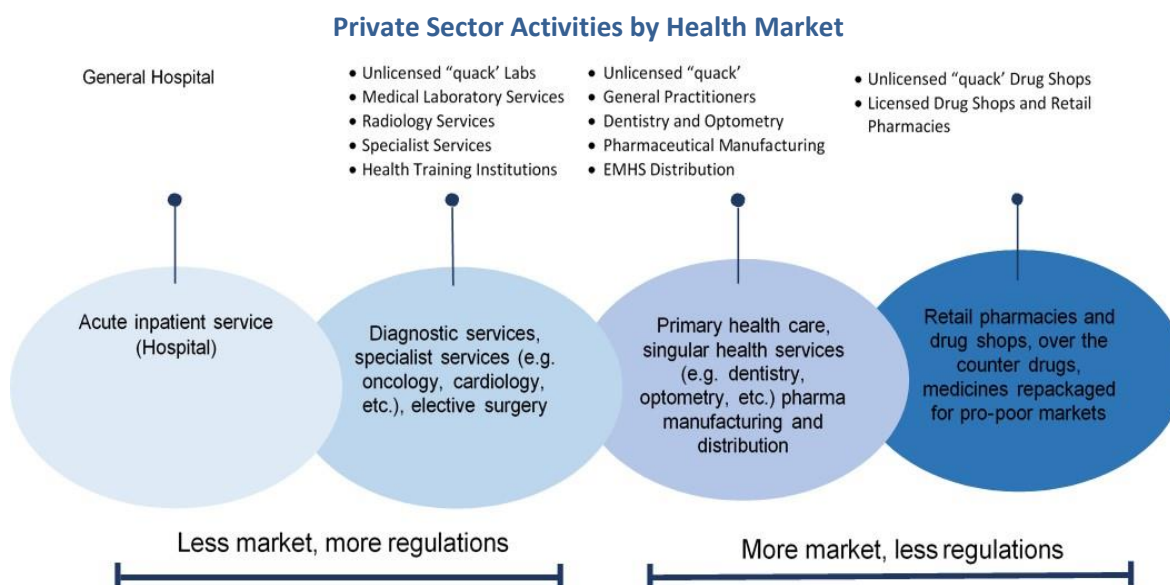
- The MoH does not have financing mechanisms in place to incentivize the private sector, particularly PHPs,

- to deliver essential health services to under-served populations. The MoH has limited experience in service contracts but the few examples, PBF and M/RH voucher programs, have demonstrated they can motivate PHPs to expand primary care to poor and rural groups. Moreover, a service contract is a more efficient way to pay for PNFP services by reimbursing them for the true cost to deliver services and linking performance to payments.
- National health insurance can help address both system as well as market conditions. Implementing a NHI can be instrumental in expanding access, addressing equity issues and reducing OOPs. But introduction of the NHI as proposed that includes both public and private providers can also help grow private health insurance and consolidate CBHIs.
- Without pooling and strategic purchasing, the MoH misses regulatory benefits requiring private providers to modify their behavior to: i) comply with national quality standards; ii) keep costs down through negotiated reimbursement rates; and iii) link payment to provider performance.
- Pooling and strategic purchasing can also help MoU to manage non-state providers. The MoH can use these financing mechanisms to i) organize atomized, individual PHPs into service delivery networks; ii) better coordinate and avoid duplication of infrastructure, staff and other resources; iii) stabilize the HRH labor markets, and iv) provide predictable markets that encourage PNFPs and PHP to expand.

4.7. Recommendations to Create a More Financially Sustainable Private Health Sector

- **Lobby the GoU to move forward with the NHI.** Although great uncertainty remains, both public and private stakeholders can come together to produce the evidence demonstrating health and system benefits, and to form various coalitions comprised of different stakeholders to pressure the GoU to act.
- **Help grow private health insurance market.** With the impetus of the NHI, the MoH can also create a more favorable policy environment for private health insurance by: i) implementing the new Health Insurance Act, ii) creating a level playing field in the insurance marketplace by ensuring private insurance companies and private healthcare providers are part of the NHI, iii) promoting greater efficiency in private health insurance industry; and iv) creating opportunities for private health insurance companies to go “down market”. The CBHIs will also benefit from the proposed regulatory reforms.
- **Take “baby” steps in health finance reforms to build the foundation for NHI.** Short- and medium-term steps include: i) harmonizing the M/RH voucher programs; ii) implementing PBF in the health sector; iii) expanding RBF now and not waiting until all the MoH systems are designed and in place; iv) establishing a drug benefit plan for the informal sector, and v) leveraging financing mechanisms to shape health markets and influence private provider behavior.
- **Improve private sector access to financing** by: i) strengthening private providers’ business management skills; ii) increasing lenders and business borrowers’ knowledge of the health care sector; iii) assisting the formal financial sector to set favorable conditions for loans; iv) expanding access to micro leasing, particularly to purchase equipment and make facility upgrades to meet quality standards; and v) offering credit guarantees.

5. PUBLIC-PRIVATE MIX IN HEALTH SERVICE DELIVERY



A review of OECD country health systems exhibits certain patterns of public-private mix (PPM) in health sub-sectors. Certain health markets tend to be governed in ways that permit more market forces while others are consistently governed in ways that strongly limit or remove market forces (see figure). The PSA Team conducted secondary analysis of the 2011 Uganda Demographic Health Survey (UDHS) and 2016 DHIS2 data to determine the PPM of key health services. As the analysis shows, certain health markets in Uganda follow the same patterns as those in OECD countries. For example, pharmacies and drug shops are more market/private sector oriented while ARV treatment and diagnostics require more regulation and supervision.

5.1. PPM in HIV/AIDS Services

Source of HIV/AIDS Funding. The 2012 NASA reveals that in 2010, public sources of funds contributed just 10.3% of overall HIV/AIDS spending while external sources (primarily PEPFAR) contributed 67.3% and 22.4% came from private sources – of which 21.7% is estimated to be household OOP payments. To address the over-reliance on donor funds, the HIV Investment Case proposes potential domestic sources of funding for HIV/AIDS: i) a NHI, if implemented, could direct 30-35% of its funds (approximately \$24 million annually); ii) oil/mineral industry could direct 0.8% of its revenues proceeds (approximately \$24.5 million annually); iii) a social investment exchange, modeled after initiatives in South Africa and Kenya, could contribute 50% of the required amount to bridge the gap; and iv) the AIDS Trust Fund could provide \$100-\$250 million annually for HIV/AIDS service provision. To date, the GoU has not acted on the Investment Cases recommendations nor launched the AIDS Trust Fund.

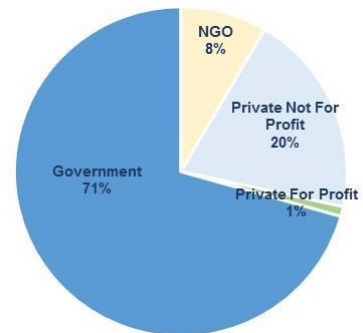
PPM of HIV/AIDS Services. Most HIV/AIDS care and treatment is delivered in a public and PNFP (FBOS and NGOs) facility. PEPFAR funds focus almost exclusively on these types of providers. It is important to note that the UDHS does not distinguish between PNFP and PFP providers so the Team relied on DHIS2 data.

- **HIV Test:** Most women (81%) reported receiving their last HIV test in a public facility while 18% tested in a private facility (PNFP or PFP). This health seeking pattern does not differ for men. Of the public facilities, 46% of HIV tests occurred in a hospital and another 31% in a health center.

Of those tested in an urban area, 68% of women received their test in a public facility while 24% tested in a private (mostly PNFP) hospital and 7% in a stand-alone VCT outlet, drug shop, private physician or TASO/NGO facility.

- Source of ARTs:** Of the men and women ages 15-49 who report they are currently taking ARVs daily, 71% obtained their medicines from a public facility (either a MoH hospital or health center) and 29% received treatment from a private provider (20% at a FBO, 8% at a NGO, and 1% at a PFP facility) (see figure). According to 2015 DHIS2, the private sector treats than ½ million active users of ARVs in Uganda.
- Source of SMC:** Three quarters (75%) of all SMCs are performed in a public facility while one quarter (25%) in a private facility. Of those performed in a private facility, the largest percentage occur in a FBO facility (17%), followed by a NGO health facility (6%) and PFP facility (2%).
- Source of PMTCT:** Most women (89%) receive PMTCT services in a public facility compared to a private (11%), mostly PNFP facilities. Of all the urban facilities offering PMTCT, 80% are public and 20% are private (both PNFP and PHPs). While in rural areas, 91% of facilities offering PMTCT services are public and 9% private, mostly PNFP facilities.

Public-Private Mix of ART



Source: DHIS 2, Jan-Dec 2015

Key Findings. When talking with private providers about HIV/AIDS services, the PSA Team learned:

- There is considerable switching between sectors by active ARV patients.* A 2015 retrospective health-seeking behavior survey found that 1/3 of ART patients switched providers when deciding where to access HCT, receive initial care, and obtain ART. Factors influencing provider choice include proximity, quality, waiting time, and provider recommendation/referral.
- Most PHPs serving HIV/AIDS clients are largely earning marginal profits* and struggle to meet costs despite perceptions they are “in it for the money”. Most PHPs arbitrarily set their fees and drug mark-ups rather than an analysis of costs. Moreover, most PHPs do not have strong business skills to analyze cash flow, estimate revenue and carryout strategies to strengthen financial/operational efficiencies.
- There is a general lack of clarity regarding what fees can be charged* by both PNFPs and PHPs accredited to access free supplies. While recent case studies state that the MoH requires facilities to dispense the drugs free of charge, both facilities and MoH/GOU staff interviewed had a wide range of interpretations of what this means in practice.
- Donor funds crowd out PHPs.* PHPs have mostly avoided delivering HIV/AIDS services because they cannot compete with MoH and PNFP who are heavily subsidized by donor funds. Further, PHPs are often not willing to access donor sponsored program so due to time constraints in completing paperwork and limited staff to dedicate to staff to data management and reporting.
- Private providers are not being harnessed to reach targets.* While PHPs are not generating as high of ART patient volumes as the PNFP subsector, most PHPs interviewed expressed a desire to play a bigger role. Market incentives, such as contracting and NHI, can tap into larger PHPs with considerable infrastructure and resources that can be leveraged to help meet Uganda’s aggressive ART targets. Smaller PHPs, however, will need MoH and/or donor program support to help overcome the challenges they confront in delivering HIV/AIDS services.

- *Nearly all private sector providers reported they would welcome more formal interaction with the public sector through contracting, subsidies, donations, tax breaks, or other financing mechanisms. Also, they would like to more feedback on performance as well as regular updates on clinical guidelines and other MoH guidance.*
- *The MoH has successful partnering experience with PHPs.* The MoH recognizes that some patients may prefer a private provider who would otherwise not access services due to stigma and created an accreditation program for PHPs. MoH records show that 80% of accredited PHPs use donated test kits and ARTs at no cost to the patient. However, many of the PHPs require MoH or donor project support –to assure quality.
- *Private sector engagement in the new guidelines for HIV/AIDS care like Test-And-Treat and PreP is not robust enough. If investment focuses on only high-volume sites, the private sector may be priced out of HIV/AIDS services.*
- *PMTCT is mainly in the public sector because the accreditation process is bureaucratic and tedious for the private sector*
- *The HIV/AIDS data mechanisms largely exclude private sector contribution to care*

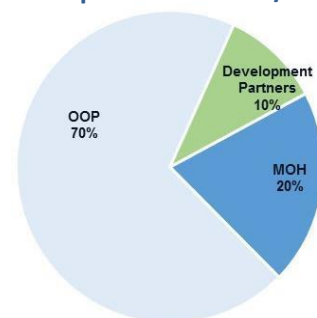
5.2. PPM in Maternal and Reproductive Health (M/RH)

The MoH developed the Sharpened Plan/Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), which aims to accelerate the reduction in maternal health and to achieve the national targets set in the Health Sector Development Plan (HSDP) 2015-2020. However, this strategic document, as well as the Safe Motherhood Program, focus mainly on a public sector response and do not clearly outline the role the private sector can play in complementing MoH’s efforts.

Source of M/RH Funding. Insufficient resources are allocated to M/RH services. The 2011/2012 NHA states that UGX 566,404 billion were spent on M/RH, which is approximately the same level from the previous year. To put this amount in perspective, government’s health expenditure for same year was three times more on HIV/AIDS (37.5%) compared to RH services (12%).

Women bear the financial burden for maternity services. The NHA 2011/12 shows that the principal source of financing for M/RH is OOP expenditures (70%) while public funds account for 20%, followed by donor aid at 10% (see figure).

Source of Expenditure for M/RH Services



Source: NHA 2011/12

When examining the funding sources by type of M/RH services, individuals pay less OOP for FP and other RH conditions (1%) compared to maternity (59%) and (41%) perinatal services (41%). Development Partners are the principal funders for FP/RH explaining why OOP is so low in this area. Two M/RH voucher programs have also helped remove economic barriers to maternity care by providing these services through PHPs at a minimal cost the mothers.

Due to relatively poor performance on MCH MDG indicators, much of the PBF roll-out financing is focused on M/RH services. However, the resources mobilized using the GFF mechanism are largely invested in the public sector.

PPM of Maternal Health (MH) Services. As the 2007 SPA shows, few public and private facilities have capacity to deliver the full range of maternal health services to Ugandan women.

Approximately 71% of all public and private facilities nationwide provide ANC services while only 53% offer normal delivery services, and only 5% can perform Caesarean sections. There are regional disparities in maternal service provision; Kampala, Central and East Central have the most health facilities providing a range of MH services while Northeast and Eastern Regions have the least.

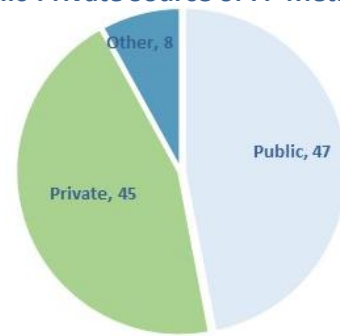
- **Source on ANC Services.** Most women seek ANC services in a public facility. According to 2015 DHIS2 data, 83% of pregnant women receive ANC care in a MoH facility compared to 17% in a private health facility (1% NGO, 14% PNFP and 2% PFP. Further, 79% of urban mothers seek ANC services from a public provider compared to 19% by a private provider (both PNFP and PHP). The public sector is also the largest provider of rural ANC services: 88% public compared to 9% private. All PMTCT services are almost exclusively in public facilities. However, the public sector is subsidizing a significant percentage of women who can afford to pay for ANC visits (10% of richer and 20% of richest) while 5% of the poorest and 8% of the poor pay for ANC services with a PHP.
- **Source of Delivery Care.** Too many Ugandan women still deliver at home: 42% deliver at home with unskilled attendants. Of those who deliver in a facility, 44% deliver in a public facility and 13% deliver in a private – either PNFP or PFP – health facility. In urban areas, 10% of women deliver at home but 63% deliver in a public facility and 26% in a private hospital or clinic. In contrast, in rural areas, 47% of women deliver at home compared to 41% in a public facility, and 11% deliver in a private hospital or clinic.
- **Who Pays for Delivery Care.** The MoH subsidizes a significant proportion of wealthy women to deliver for free in a public facility. Although a growing number of women in the top three income groups deliver in a private facility (11% for middle-income, 16% for richer, and 28% for the richest) an important percentage of these women who can afford to pay deliver in a public facility (40% middle-income, 43% richer and 60% richest). Redirecting wealthier women to PHP will free up substantial public resources to encourage poorer women to deliver in a facility with a skilled attendant.
- **Source of Post-Natal care.** Few women (33%) attend a post-natal visit even though 60% of maternal mortality occurs during the post-natal period. Cost and convenience as well as the fact that majority of deliveries occur at home are reasons why most mothers do not return to a health facility. Of the women who do attend a post-natal visit, 77% go to a public facility while 16% seek care in a private one.

PPM of Family Planning (FP). Contraceptive prevalence is still very low in Uganda compared to other SSA countries. Only 30% of women of reproductive age use some form of contraceptive, of which 26% is a modern method. Ugandan women prefer injectables (47%), followed by the pill (10%), and sterilization/implants (9% each). IUDs are the least popular method (3%). The type of method has implication for the private sector. Medical dependent methods, such as long-acting reversible contraceptives are more difficult to deliver through private channels, such as private providers and pharmacies, without modifications in scope of practice and robust quality assurance measures to ensure safe delivery and management of contraindications.

In Uganda, FP is a different market compared to HIV/AIDS and maternal health.

- **Source of FP.** The private sector plays an important role in delivering FP methods. In Uganda, 47% women source their FP method from a public facility while 45% women get their FP supplies from a private one (see figure).
- **Source by Method.** PHPs play a different role depending on the method. Female sterilizations and implants are largely performed in the public sector (79% and 85%, respectively). Injections are mostly sourced in the private sector; 60% compared to 39% from the public sector. And pills and condoms are equally from both public and sectors (46% private compared to 52% public for pills and 46% private compared to 45% public for male condoms).
- **Who Pays for FP.** The FP market is better segmented by income groups compared to HIV/AIDS and maternal health. Most (70%) women in the poorest and (50%) poorer quintiles obtain their FP method for free at a public facility while most (67%) of the wealthiest women rely on the private sector. Yet a large percentage of the poorest (27%) and poorer women (45%) still get their FP method from a private facility, primarily because of the constant stock-outs in public facilities.
- **Mismatch between supply and demand.** A significant proportion (46%) of public facilities do not have pills in stocks yet experience lower stock-outs rates for IUDs (5%) and implants (13%). Moreover, MoH facilities have constant supplies of injectables (almost 100%) and condoms (93%). Most private facilities (63%), on the other hand, have a steady stock of pills but cannot offer Ugandan women’s preferred methods: 82% do not offer implants and 30% do not offer injectables. This is a missed opportunity to harness the private sector to increase access to a wider range of modern FP methods.

Public-Private Source of FP Methods



Source: UDHS, 2011

5.3. Key Findings

When talking with private providers about M/RH services, the PSA Team learned:

- *The Uganda health sector is not delivering on the promise of safe motherhood* despite its policies and strategies to reduce maternal mortality. GoU and donors are not allocating sufficient funds and technical assistance to expand M/RH services irrespective it is a public or and private provider. Almost all PMTCT services are provided in the public sector
- As a result, *the financial burden has fallen on mothers and their families*, as demonstrated by the high OOP cost for maternity services. FP, on the other hand, is highly subsidized by donor funds in both the public and private sectors and therefore, women pay less OOP for their FP method. Directing women who can afford to pay to a private facility could free up much needed public resources to focus on the poorest income groups.
- There is *consensus among MoH officials that working with PHP is possible strategy to decongest public facilities*. While MoH facilities are overcrowded, there are many qualified PHPs nearby that are underutilized. Studies show women prefer a PHP because access is easier since they are often located in a woman’s community, they offer longer clinic hours and shorter waiting times, and they are highly respected by the community. There is room for leveraging the PACE and MSI networks of private midwives to help achieve M/RH goals as has been done in other countries in the region and globally.

- *Most private midwives report struggling to earn a small profit or to meet costs.* Although private midwives deliver the same services as PNFPs to a similar clientele, they do not receive benefits such as GoU subsidies or donated commodities. Although the M/RH voucher program has helped many private midwives to stabilize their incomes, these programs are not located in the same regions where private midwives practice - Kampala.
- *Private providers will need government and donor support to overcome the barriers to delivering M/RH services and products.* Challenges include: i) lack of specialist staff; ii) difficulty in retaining staff who prefer MoH working conditions and benefits; iii) out-of-date skills with few training opportunities; iv) wide variation in quality of services with limited MoH supervision; and iv) client inability to pay for services.

5.4. Recommendations

To strengthen the private health sector's contribution in HIV/AIDS services

- The MoH can take the following actions to better leverage private sector providers' contributions to HIV/AIDS: i) conduct regular National AIDS Spending Assessments to generate up-to-date data to inform planning for HIV/AIDS services; ii) allow private providers to access existing continuous professional development opportunities; and iii) clarify allowable fees for HIV/AIDS services under the ART accreditation program.
- Explore several concrete partnership opportunities that have demonstrated success in both SSA and other developing countries. Examples include: i) segmenting those who can pay for services and steering them towards PHPs; ii) formalizing and strengthening the HIV/AIDS referral system between public and private providers (South Africa "down referral" model); iii) contracting private midwives to integrate PMTCT into their current services (Tanzania); and iv) establishing private pharmacy networks to treat opportunistic infections and TB (Vietnam example).
- The Government should ease the bureaucratic accreditation processes for ART and PMTCT service provision for the private sector
- The MOH should develop guidelines on costing of services
- The MOH should include and improve data collection and management for the private sector

To strengthen the private sector role in M/RH services

- Create partnerships to organize and integrate private providers (PNFP and PHPs alike) to compliment MoH efforts to improve mother and child health conditions in Uganda. Opportunities include: i) allowing private providers to access existing continuous professional development opportunities; ii) leveraging financial mechanisms, such as NHI (Tanzania), service contracts (Philippines) and/or vouchers (India), to organize PHPs into networks that the government can contract to provide specific services; iii) contracting private delivery networks, like PACE and MSI, to decongest MoH hospital maternity wards; iv) supporting private pharmacies to deliver a wide range of modern FP methods, including injectable; and v) establishing mobile FP services to increase the use of FP methods targeting rural and remote areas (Zimbabwe and Madagascar), vi) supporting and strengthening the Joint Medical Stores and the Uganda Health Marketing Group that manage the private sector M/RH commodities supply chain.

6. ESSENTIAL MEDICINES AND HEALTH SUPPLIES (EMHS)

Over the last two decades, the demand for EMHS in Uganda has increased steadily, with most of the growth occurring in the private sector and in urban centers where most pharmacies and drug stores are located. Most of the studies have focused on public and PNFP supply chain systems for EMHS yet the private sector is dynamic and active in all segments of the supply chain and is often overlooked as a potential partner in creating a more efficient system to deliver, quality and affordable medicines.

6.1. Enabling Environment

The MoH has in place a policy framework supportive of private sector role in the pharmaceutical sub-sector. The policies include the NMS Act (1993), the National Drugs Policy and Authority Act (1993), the Public Procurement and Disposal of Public Assets Act (2003), and National Medicines Policy 2015. These policies allow for non-state actors to participate in all aspects of the supply chain.

However, there are several challenges in both the regulatory and institutional framework governing the pharma sub-sector.

- Current regulations contain several out-of-date and contradictory provisions. For example, there are not regulations governing wholesalers and distributors. Moreover, laws contradict policies and current practices in the areas of medical equipment and new medicines.
- Institutional arrangements governing the private sector is highly fragmented. Five entities are responsible for performing different regulatory functions: i) the MoH Pharmacy Division and National Drug Authority (NDA) have duplicate responsibilities, creating uncertainty in this sector as to who is the lead authority; ii) three agencies – NDA, Pharmacy Council and Allied Health Professional – are responsible for licensing professionals; and iii) two agencies – NDA and Allied Health Professionals – license and inspect facilities.
- The divided regulatory system has created cumbersome licensing and reporting requirements. All PHPs interviewed agree it is imperative that everyone comply with these obligations. But current licensing processes are confusing, time consuming, and costly for private providers. Moreover, the MoH reports are burdensome with no perceived benefits since PHPs never receive feedback.
- Enforcement of regulations in the private sector is weak. Although NDA oversight appears to be improving, more needs to be done in the areas of: i) facility licensing, ii) drug storage and iii) pharmacist absenteeism. As a result, informal drugs stores and unlicensed pharmacies flourish without impunity.
- There are limited interactions between public and private stakeholders in this sub-sector. Although the NDA involved private sector stakeholders to participate in the design of the current National Pharmaceutical Strategy, stakeholders shared they are rarely invited to participate in MoH policy and planning discussions. Private entities – manufacturers, wholesalers and distributors, and retail pharmacies – feel they are operating in isolation from the MoH, do not regularly receive new policies and guidelines as they are published, and the only time they interact with the MoH is during a site inspection.
- Protectionist state policies that limit business opportunities for the private sector in the healthcare commodity space

6.2. PPM in the Pharma Sub-Sector

PPM in Supply. There are three parallel supply chains in Uganda: i) the public supply chain system led by the National Medical Stores (NMS); ii) the PNFP supply chain managed by the Joint Medical Stores (JMS); and iii) numerous procurement agents, manufacturers, distributors and retail pharmacies in the private-for-profit sector, including Medical Access Uganda and the Uganda Health Marketing Group. There is some coordination between the three supply chains but the fragmentation creates problems for their managers and respective service providers, including i) staffing shortage; ii) wastage and stock-outs in the NMS supply chain; iii) duplicate inventories and storage systems across sectors; and iv) cumbersome and duplicative reporting requirements.

Donors have exacerbated the fragmentation of the supply system. In 2002, the public system received a dramatic influx of donor funds to push critical drugs needed to respond to the HIV/AIDS epidemic, establishing a vertical supply chain for HIV/AIDS and TB drugs and supplies. In some cases, the national programs used the same product but sourced and financed by different donors. In other cases, some donors did not trust the MoH's capacity to handle their commodities and created another vertical, private supply chain.

Health consumers suffer the most from this fragmented and inefficient supply chain system. The public sector continues to experience stock-outs, forcing consumers to pay market prices for their drugs at a private pharmacy or drug shop. Quality of the drug supply, particularly in drug shops, is suspect. And drug costs are the most expensive component in healthcare, often leading to impoverishment.

There is intense unregulated competition in the pharma supply chain from TCMPs.

PPM in Pharma Activities. The private sector is active in every stage of the supply chain starting with importation and distribution, to local production, and to retail pharmacies (see table). As the table shows, there are significant data gaps in segments of the pharma sub-sector; a direct outcome of the fragmented and inefficient regulatory framework.

Public-Private Mix of EMHS Organizations

Type of Entity	PFP	PNFP	Private Sub-Total	Public	Total
Importers	68	1	69	1	70
Manufacturers	8	0	8	1*	9
Wholesalers/Distributors	N/A	N/A		-	372
Pharmacies (Retail)	N/A	N/A	901	1,002	1,903
Drug Stores	N/A	N/A	5,984	-	5,984

Source: NPSSP III, APSPR 2013/14, UNIDO 2010 report. * Quality Chemicals is a joint venture

PPM in Pharma

Staff. There has been a 10% increase in the overall number of practicing pharma personnel; for example, pharmacist to population ratio increased from 1.1 pharmacists per 100,000 persons in 2010/11 to 1.6 in 2013/14. Although similar than other SSA countries, this ratio is still low compared to other low and middle-income countries. The majority of HRH for the pharma sub-sector work in the private sector: 93% of pharmacists and 69% of pharmacy technicians are employed in a private facility. Moreover, almost 90% of these pharmacists are concentrated in the central region, creating HRH shortages in other regions in Uganda. The MoH struggles to recruit and retain qualified pharmacists, leaving other health cadres without proper training to carry most of the pharmaceutical management functions. Finally, stakeholder interviews and site visits revealed there is considerable dual practice among public sector pharmacists who own a private pharmacy located close to a public facility.

PPM Pharmacists and Pharmacy Technician

Pharmacy Personnel	Private	Public	Total
Pharmacists	916	69	985
Pharmacy Technician / Dispenser	318	233	551

Source: APSPR 2013/14.

6.3. Drug Expenditures

Financing EMHS is a major challenge in Uganda. Although financing allocated to medicines has increased significantly, this increase is due in large part to the advent of global health initiatives such as PEPFAR and Global Funds. From 2010 to 2014, overall expenditure on medicines increased by an average of 27% per year from UGX 258 billion in 2010 to UGX 846 billion in 2014. As noted earlier, government health expenditures have remained mostly stagnant over the same period when excluding donor funds: UGX 202 billion in 2010 to UGX 219 billion in 2014, resulting in stagnate per capita spending on EMHS during this period at an average of USD \$2.40. Excluding ARVs, ACT's, TB supplies, and vaccines, government per capita expenditure decreases to USD \$0.98. Clearly there is need to increase government allocations to the MoH to cover EMHS costs, but according to a World Bank report, there is also space to improve efficiency in the public supply chain.

The burden of paying for medicines and other health supplies has fallen on individual households. According to the NHA 2012/13, 73.9% of all drug expenditures is financed by private, mostly individual OOP, sources, while government and Development Partner contributions fund 26.1%. As noted earlier, purchasing medicine is the number one OOP expenditure (59%).

Drug prices vary between public, PNFP and PHP providers. Although the MoH prohibits charging for medicines, several reports have documented MoH clients informally paying a MoH worker for drugs. PNFP prices are consistently lower than PFP prices. However, in some cases, NGO prices were higher than those in PFP pharmacies. Retail mark-ups range from 50% to 600% in private pharmacies with lower mark-ups for donor supplied commodities. The price variance underscores the need for the MoH to put in place guidelines to rationalize prices and to protect consumers from impoverishment due to drug costs.

6.4. Key Findings

From the private sector perspective, their concerns about the pharma sub-sector include:

- *Parallel supply chains have created inefficiencies, jeopardized drug quality and delivery, and driven up costs.* Until the government and international donors decide on how to approach consolidation of the three supply chains, this situation will persist. As result, private businesses operating in the private supply chain will continue to do “work arounds” to survive in this environment, perpetuating inefficient distribution and high costs.
- *MoH facilities drug stock-outs leaves the private sector as the defector supplier of medicines in Uganda,* leaving the poor to be disproportionately affected by the high prices in the private sector.
- *Current policies and institutional arrangements negatively affect quality in the private sector.* The fragmented regulatory system allows for unscrupulous practices by public (e.g. dual practice) and private pharma providers (absent owners). Private pharmacies do not consistently comply with licensing and reporting practices.

Moreover, key regulatory agencies like NDA lack staff, capacity and tools to inspect and close facilities. The growing number of “quacks” influences consumer perception of quality in licensed private pharmacies and drug stores.

- *Competitive market due to low barriers to entry.* The ease of opening a retail pharmacy or drug shop makes this sector, especially at retail level, a low cost, high volume and low margin business. Mark-ups and retail prices are set arbitrarily, ranging anywhere from 50% - 600%. The competitive market has artificially capped prices, but at high levels, which have remained stagnant in recent years.
- *Market conditions do not create incentives to invest in the supply chain.* Tough competition in the distribution market in the pharma system has created a race to the bottom on prices and margins. In the absence of MoH policies to consolidate the number of distributors, there no incentive to invest in establishing regional warehouse and nationwide distribution system.

The business environment also limits growth in local manufacturing of drugs and health products. Although the National Drug Policy provides tax incentives, tender preference, reduced import tariffs on inputs, reduced rates for electricity and water consumption, it is difficult for private manufacturers to access these benefits due to burdensome requirements. Moreover, Ugandan manufacturers have to compete with Indian and Chinese companies that receive direct subsidies from their governments.

- *Limited public-private collaboration has created market uncertainty.* There is no formal mechanism and/or policy platform that benefits all actors in pharma. This situation is further compounded by the lack of regular and consistent communication between the MoH and private stakeholder groups. Until recently with the NPSSP and NMP policies, the MoH been reluctant to involve the private sector to policy discussions. But when the MoH does include the private sector, they invite only the “big players”, creating “favorites” and/or “monopolies” in the sector.
- *The private sector remains an untapped resource.* Despite the private sector’s dominance in many areas of the pharma supply chain, the MoH has been reluctant to enage and/or partner with private pharma businesses to fully exploit their infrastructure and expertise to overcome challenges endemic in the public supply chain.

6.5. Recommendations to Improve Availability and Quality of EMHS

- **Streamline and modernize the regulatory system governing EMHS supply.** Areas to pursue include: i) consolidating and streamlining the government institutions responsible for oversight; ii) clarifying the newly consolidated roles and responsibilities; iii) modernizing oversight systems and tools to make the regulatory agencies more management oriented and “user-friendly” to the private sector; and, iv) collecting better data on *all* supply chain activities including the private sector.
- **Assist JMS to establish regional warehouse network.** The GOU can assist JMS to raise needed capital in invest in a nationwide distribution system that will also benefit the MoH by: i) guaranteeing a commercial loan; ii) lending the funds to JMS with favorable terms; or iii) entering into a PPP arrangement in which JMS builds and operates on behalf of both JMS and NMS.
- **Help grow local capacity to manufacture key medicines and health products.** Government actions include: i) offering tax exemption on imports of raw materials and machinery; ii) reducing costs of inputs such as water, power, etc.; iii) promoting Ugandan manufacturing in other markets, particularly East African markets where Ugandan companies are competitive; and, iv) assisting local manufacturers to qualify for GPP certification and WHO prequalification status.

- **Make drugs and essential health products more affordable.** The POA outlined recommendations such as i) creating guidelines to establish minimum/maximum ranges for mark-ups on key drugs only, ii) establishing affordable MoH prices to recoup costs and iii) establishing a drug benefit plan for the poor to remove economic barriers to essential medicines iv) encourage exploitation of economies of scale by bulk procurement of pharmaceutical supplies
- **Support the growth of Medical Access Uganda and the Uganda Health Marketing Group to increase competition in the supply market in pursuit of efficiency gains in the supply chain space**

7. MEDICAL LABORATORIES

Effective laboratory services are an essential component of a functional health care system because labs not only generate information that enable timely and accurate diagnosis of disease but also play a key role in disease surveillance. Although a vital component of Uganda’s health system, this sub-sector has been one of the least developed and neglected in Uganda.

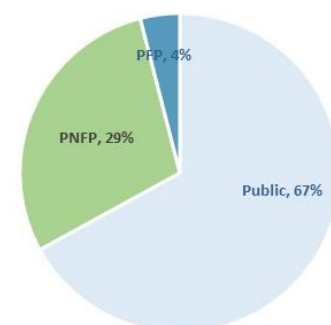
7.1. Enabling Environment

The medical laboratory sub-sector shares many of the same characteristics as the pharma sub-sector. The policies and regulations governing this sub-sector are recent; they have been in place since 2009. These policies germane to the lab sub-sector *all* support a private sector role in medical laboratories. However, the oversight roles is fragmented between the NDA, AHPHC and Central Public Health Laboratory (CPHL). There is no clear and coordinated system to assure quality allowing for unscrupulous practices. Further, there are important policy gaps regulating non-state medical laboratories: entry to market is too easy, allowing “quack” labs to operate side-by-side licensed private laboratories; and there are critical gaps in policies, such as sourcing for tests from credited suppliers to ensure quality.

7.2. PPM in Medical Laboratories

There are three parallel delivery mechanisms of lab services – government, PNFP and PHP. These delivery systems operate in different spheres with limited interaction and coordination. Donor funds from PEPFAR and Global Funds have greatly shaped the laboratory sub-sector. The rapid influx of donor funds has created a vertical laboratory system within the public one, which has further fragmented the lab sub-sector. The only integration and coordination occurs between the MoH and PNFP labs. The MoH interacts closely with PNFP laboratories through supportive supervision, donated supplies, training and proficiency testing. This type of coordination and support does not occur with PFP laboratories.

PPM of Medical Laboratories



Sources: Annual Health Sector Performance Report, 2014/15; Medical Bureaus Delivery Statistics, APHC facility registry

Health Facility Level	Lab Level	Public	PNFP	PHP	Private %	Total
Referral Hospital	Level 3	2	0	0	0%	2
Regional Referral Hospital	Level 3	14	0	0	0%	14
General Hospital	Level 2	49	63	27	66%	139
HC IV	Level 2	182	17	7	12%	206
TOTAL		247 (68%)	80 (22%)	34 (10%)	32%	361
Stand Alone	Depends on scope	0	0	11	100%	11
Individual clinicians with labs	Unclassified	0	0	N/A	N/A	N/A

Sources: Annual Health Sector Performance Report, 2014/15; Medical Bureaus Delivery Statistics, APHC facility registry

There are over 1,000 medical laboratories in Uganda, but data is difficult to get for those housed in HC III and below (see table). The MoH owns and operates 68% of all registered laboratories compared to PNFPs (22%) and PFPs (10%). The MoH laboratories include the referral and Regional Referral Hospital laboratories as well as HC IV and hospital laboratories. PNFPs laboratories are mostly in FBO hospitals and HC IVs. There is a growing, albeit small, number of stand-alone PFPs laboratories. In addition to these licensed medical laboratories, there is large, unknown number of unsupervised laboratories located in individual clinicians' private practice. The number of clinical owned labs has proliferated, especially in urban centers. And there are many "quack" laboratories that are also unregulated and unsupervised.

Quality of medical laboratory services varies greatly across the sectors. In general, PNFP laboratories are considered to have consistently better quality lab services while the PFP sector laboratories have both the "best" and "worst" quality. The private, stand-alone laboratories have state-of-the art equipment, constant supply of reagents, along with highly trained staff. Yet they operate along-side "quack" labs. Quality in the public sector is also uneven. The MoH owns and operates the most sophisticated referral laboratory services in Uganda. Yet at the same time, many MoH labs are inoperable due to lack of staff and/or commodities such as reagents.

7.3. Key Findings

Key findings emerging from the stakeholder interviews and other sources include:

- *PFP is active and growing in the lab sub-sector, driven mainly by demand.* Key reasons cited why clients go to a private stand-alone lab include convenience, longer working hours, and quick turnaround service. Often consumer have no choice and opt for a PFP lab when a MoH lab is not functional.
- *Yet the PFP sector face difficult enabling environment:* i) the sector is not producing sufficient number of clinical and allied staff for this segment in the health system; ii) there are weak regulations and oversight in this sub-sector; iii) uncertain quality is negatively influencing consumer perception of PFP labs; and iv) competition from "quacks" is suppressing demand.
- *Public and private medical lab systems operate in different spheres with limited interaction.* PFP providers are least organized in this sub-sector compared to pharma and health service delivery, making dialogue and coordination difficult for the MoH. Yet, PFP stakeholders interviewed indicated a strong desire for better coordination and to partner with the MoH to address challenges delivering lab services. However, there is limited experience in bringing together for public and private stakeholders and there is no platform to dialogue. Moreover, government officials in this sub-sector are slow to embrace working with PFP lab owners.
- *The medical laboratory sub-sector is inefficient.* In the public sector, there is high demand for laboratory services but many MoH laboratories are non-functioning.

In the private sector, there is also excessive demand in PNFP laboratories because of affordable prices and high quality services. Yet there is underutilized capacity in the PFP sector that is not tapped to address the capacity issues in both MoH and PNFP labs.

- *PFP laboratories face tough market conditions.* The private stand-alone laboratories, unless part of a SSA chain, struggle to survive and further cut prices to drive volume. As a result, prices are artificially low compared to other East Africa countries and in many cases insufficient to recuperate operating costs. Private lab owners also have limited access to capital to purchase equipment and/or to expand services. And there are no tax exemptions or subsidies for private labs performing HIV or other important tests.

7.4. Recommendations to Improve Access and Quality of Private Laboratory Services

- **Streamline and modernize the regulatory system.** Steps include: i) reducing the number of agencies and clarifying roles and responsibilities; ii) investing in building the designated agency's capacity, including staff and budget; and iii) modernizing systems to collect and centralize the data needed to regulate both public and private laboratories effectively.
- **Strengthen MoH capacity to assure quality.** Tasks include: i) reviewing existing clinical standards to determine if they meet international best practices; ii) establishing universal quality standards that apply to both public and private medical laboratories, and; iii) investing in a system and staff to monitor quality standards across all sectors - public, PNFP and PHP laboratories alike.
- **Promote greater interaction and dialogue.** Steps the MoH can take are: i) inviting PNFP and PHP to participate in policy design and implementation; ii) sharing information, communicating more frequently and interacting with private sector providers; and creating a "space" for PHP lab owners/operators to share new technologies and innovations with the public sector
- **Establish a Referral/Counter-Referral System.** A simple, low risk collaboration between the public and PNFP and PFP lab owners is to develop a comprehensive directory of all public and private laboratories. This type of collaboration often generates other ideas on how to work together, as was the case in Tanzania.
- **Co-locate a PHP lab in public or PNFP facility.** MoH can explore partnership arrangements, such as co-location (Kenya), to equip public laboratories with state-of-the art equipment, ensure constant supply of reagents, train MoH staff in the use of modern equipment and improve diagnostic skills.
- **The wider diagnostics market opportunities should be documented to encourage private sector participation in the diagnostics space**
- **Strengthen regulatory capacity to limit supplier-induced demand for un-necessary laboratory and other diagnostic services in the private sector**
- **Institutionalize quality assurance and appropriate data management mechanisms in the laboratory and diagnostics in the private sector**

8. HUMAN RESOURCES FOR HEALTH (HRH)

An effective health system needs a qualified and accessible health workforce that can provide quality health services to all. Without this backbone of skilled HRH, a country like Uganda will not be able to achieve UHC. To ensure everyone has access to a competent health worker – no matter which sector they work in – the MoH must examine both public and private sector workforce **together** to better align and leverage HRH across the health system. Moreover, the MoH needs to acknowledge in its HRH policy and planning design, that a change in one sector can have a direct impact on the other.

8.1. HRH System

The MoH has policies and government apparatus needed to “set the rules” of the healthcare profession in Uganda. The institutional arrangement governing the healthcare profession in Uganda involves the MoH and its regulatory bodies as well four other government ministries. According to a MoH 2007 report, this multiplicity of stakeholders makes HRH planning and decision-making long, often frustrating and sometimes ineffective.

HRH Stewardship. There are two key functions that MoH plays related to HRH: i) sector-wide planning encompassing public, PNFP and PHP to assure enough skilled and well-trained HRH with the range, type and equitable distribution of HRH cadres given the disease burden; and ii) HR management of MoH staff like a major corporation with thousands of employees. In Uganda, however, these two functions are blurred, often resulting in these roles being merged. The MoH needs to separate these two functions and build MoH capacity in each of them.

The MoH has made important strides in HRH planning with the introduction of the HR Information System (HRIS), moving towards data driven planning. However, the HRIS only collects and analyzes data on MoH and PNFP staff and excludes data on PFPs. Data remains a problem: i) there are no standards on what type of HRH data to collect and how to collect it; ii) data is located across different MoH agencies increasing the likelihood of errors; iii) the HRH numbers do not include non-clinical staff (e.g. management) and iv) there is double counting due to dual practice. The MoH cannot plan nor understand the interaction between public and private HRH labor markets until it has accurate data on **everyone** working in the health system.

HRH Production. Uganda is a pioneer in HRH production. In the last five years, Uganda has made considerable investment in building its HRH training capacity. Development Partners have helped the GoU and PNFPs to build new HTIs which has resulted in a steady increase in production in key HRH cadres such as general nurses and midwives. The PNFP sector has become the de facto place for “industrial training” and “internships” for HRH. PNFP nurse and midwifery HTIs have adopted a wide range of innovative training approaches, such as extension programs, e-learning and long-distance learning programs.

HRH Management. The fragmented approach to HRH management greatly affects quality of MoH health services. MoH managers have limited or not authority in key personnel functions. Also, the MoH suffers from dual management creating gaps in HRH coordination and planning **internal** to the MoH: MoH manages urban facilities and tertiary hospitals while districts/local governments manage hospitals and HCI II, III and IV. Stakeholders interviewed consider PNFP and PHP management of HR to be more agile and responsive to consumer needs: i) they are not subject to the same government HRH policies and systems; ii) Bureaus have developed “modern” HRH policies and systems; and iii) larger PHP apply international HR best practices. But smaller, solo practitioners struggle to put in place HR policies.

HRH Production. As noted earlier, PNFP and PFPs increasingly play an important role in training HRH. Of the 143 HTIs, 48% are owned and operated by PFPs, 24% by PNFPs compared to 28% by the public sector. However, a significant number of the PNFP and PFP HTIs are not licensed or registered.

As a result, many of the studies who graduate are not registrable to work in Uganda. Quality of training is also a challenge in private HTIs. There is an acute shortage of qualified tutors and over-enrollment in private HTIs given government guidelines.

HRH Recruitment. The MoH struggles to recruit staff for its facilities. The MoH’s goal is to fill 75% of its open positions but to date they only filled 69%. Moreover, the MoH experiences acute staff shortages in select cadres such as anesthesiologists (33%), pharmacists (46%), allied staff (52%), and physicians (53%). Only nurse/midwives, clinical officers and lab technicians are filled to acceptable levels. Although the PNFPs track vacancies and recruitment, there is no comparable data for PHP facilities.

Interviews between public, PNFP and PHPs indicate that salary and compensation packages by sector directly impact the one’s ability to recruit and retain staff. To address staffing shortages, the MoH recently increased its compensation package (e.g. higher salaries, job security, and access to CME). PNFPs and PHPs have struggles to match these salary levels, and many PNFP and PHP staff have left their positions to work in the MoH, “robbing Peter to pay Paul” as one PNFP official shared. The MoH needs to consider HRH as an interconnect system and that what happens in one labor market will affect the others.

HRH Retention. A key study revealed that staff morale is low among HRH in *all* sectors. The MoH retains staff for a relatively long time – less than 10 years – compare to the other sectors. MoH jobs are considered high-status positions, stable and reasonably compensated. But almost half of all MoH staff would leave their job as soon as an opportunity presents itself. Reasons cited are poor working conditions, low productivity and high absenteeism. PNFPs experience high-turnover in their staff. Almost 40% state they want a MoH job and act upon this intention. PSA interviews revealed that there is also high turn-over in PHP facilities.

Although HRH consider working conditions better in a private facility, low salaries is the most cited reason for leaving. Most PHP staff leave for a MoH or PNFP position (in that order).

8.2. Key Findings

From a private sector perspective:

- *There is considerable movement of HRH between the three sectors for a variety of reasons. An informal ranking of preferred jobs between the labor markets shows that HRH prefer, in this order, public sector, PNFPs and PHPs. Working conditions are considered better in PNFP and PFP facilities compared to public sector ones; salaries are better in PNFP facilities compared to PFP ones; and all stakeholders interviewed agree that salary and job security are better in the public sector.*
- *Overall, low morale, poor working conditions and low wages plague the health system. All three sectors struggle to recruit and retain staff. The “best and brightest” often leave health to work in other sectors in the Uganda economy. Although these problems are common across all sectors, they affect each sector differently. No one HRH policy or solution will “fit” all three sectors.*
- *PHPs remain virtually outside of the HRH system. The MoH does not standardize data on PHPs. MoH policy and planning continue to focus exclusively on public and PNFP staff.*
- *All three labor markets are interconnected. Policy decisions aimed at the MoH directly impact and influence the other two sector’s ability to produce, recruit and retain staff. Yet PHPs are not involved in policy dialogue and planning related to HRH.*
- *A large proportion of private sector health workers are public sector workers and are involved in dual medical practice*

8.3. Recommendations to Manage Labor Markets across Public and Private Health Sectors

- **Modernize MoH stewardship’s capacity to guide all HRH.** As a first step, the MoH must separate its health planning function from its own HRH management. Towards that end, the MoH can improve the HRIS to become a sector-wide tool to plan and manage the overall HRH labor markets.
- **Embrace modern HR management approaches to administer MoH personnel.** Steps include: i) creating a HR Unit and elevating it to a Directorate level; ii) establishing a new cadre of MoH HR managers; iii) investing in and deploying MoH HR managers; iv) strengthening MoH recruitment and deployment practices; and v) revamping MoH supervision and performance systems, vi) develop and institutionalize a robust electronic HRH information management system
- **Strengthen Professional Associations to represent private HRH in policy planning.** Professional Associations are an important bridge between health consumers, healthcare professionals and the government. Successful approaches: i) strengthening a professional associations internal structure and organizational effectiveness, and ii) building a professional association’s capacity to carry out key member activities, such as legislative affairs, continuing medical education and accreditation to name a few.
- Government should benchmark and develop a deliberate policy and guidelines for managing dual practice.
- Reform provider payment systems to prioritize and incentivize productivity of available HRH both in the public and private sectors
- Extend training and capacity building opportunities to the private sector

9. STRATEGY AND "ROAD MAP" TO HARNESS PNFPS AND PHPS TO ACHIEVE UHC

Implementation Strategy to Harness the Private Sector

Strategy #1	Build government capacity to assure quality in a mixed health delivery system	<ul style="list-style-type: none"> • Collect standard data on private sector to inform policy dialogue and regulatory reform • Streamline and institutionalize a QA System governing quality in the private sector • Modernize tools (facility registration, professional licensing and CPD credit systems) assuring minimum quality in private sector • Strengthen MoH capacity to steward and plan HRH across all sectors • Move towards "co-regulation" of quality for private sector facilities through a 3rd party
Strategy #2	Create financial incentives to harness the private sector	<ul style="list-style-type: none"> • Encourage the MoH to implement the HFS Strategy • Assist the PPP/H Node to implement financial tools needed to incentivize the private sector to participate in PPP/Hs • Use financial mechanisms to structure the market
Strategy #3	Reduce economic barriers to health services and medicines	<ul style="list-style-type: none"> • Start <i>now</i> to grow MoH's experience in RBF including PHPs • Scale the MH voucher program nationwide and to include CH • Create a drug benefit plan for priority illnesses among the poor
Strategy #4	Build public and private sector capacity to foster PPD	<ul style="list-style-type: none"> • Foster greater understanding and awareness on the private sector and PPP/Hs • Strengthen public and private dialogue (PPD) • Strengthen public-private coordination and collaboration • Invest in the PPP/H Node's capacity and systems to partner with the private sector • Invest in structure private sector provider networks
Strategy #5	Broker targeted partnerships to increase access to health services and strengthen health systems	<ul style="list-style-type: none"> • Increase private sector role in delivery of HIV/AIDs and MCH services and products • Increase private manufacturing of basic medicines and supplies • Increase private role in medical equipment (e.g. lab, diagnostics, oxygen, and emergency transport) • Increase private role in medical infrastructure projects (operating theatres and neo-natal units)

The PSA's intent is to support the GoU and private sector stakeholders to enhance public-private engagement at all levels of the Ugandan health system. The PSA provides a comprehensive "snap-shot" of the private health sector landscape revealing the multiple services and system functions that private health stakeholders can make significant contributions. The PSA Team made multiple recommendations in each section to assist the MoH to harness the private sector. The recommendations are comprehensive and ambitious. To help the public and private stakeholders in the Uganda health system think through and prioritize the long list of possible interventions, the PSA Team proposes a strategy that prioritizes the wide range of recommendations (see below) and timing to implement them.

As Ugandan government officials and private health sector leaders embark on this journey of public-private cooperation and partnerships, the proposed Strategy focuses on laying the foundation and building the both public and private institutions so they can fulfill their respective roles in a mixed health delivery system. As both public and private sector stakeholder groups become more comfortable with public-private dialogue and collaboration, the Strategy then moves away from systems development to PPPH implementation.

Many of the recommendations are cross-cutting and will require strategic action, cooperation and engagement between the public and private sector stakeholders. As such, the PSA provides a roadmap (see below) to optimize private sector inputs and is organized by “quick wins” (6 to 12 months), “low hanging fruit” (12 to 24 months) and “long-term gains” requiring investments in system and capacity building that finally bear fruit in four to five years.

“Quick Wins”
6- 12 months

Strategy #1: Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
- Agree on and collect standardize data
- Strengthen private sector reporting to the MoH
- Streamline and institutionalize SQIS
- Build MoH capacity to interpret and report on status of quality in private sector
- Build professional associations and NMOs to apply SQIS with members
- Continue implementation of modernized tools in MoH and private institutions

Strategy #2: Create financial incentives to attract private sector to partner with MoH

- Advocate with the GoU to approve the NHI Bill
- Take steps that will create the foundation for a NHI Scheme
- Segment those who can afford to pay and “steering” them to the private sector
- Advocate for inclusion of PPPs in MoH RBF initiative

Strategy #3: Reduce economic barriers

- Harmonize two MH voucher programs
- Assess feasibility of a DBP for priority illnesses among the poor

Strategy #4: Build public/private capacity in PPP/Hs

- Foster greater understanding and awareness on PPP/Hs
- Disseminate widely PSA findings and recommendations and present international and local experience on PPP/Hs
- Strengthen PPD and coordination at national and regional levels by
 - Embedding PPP/Hs in HPAC and strengthen its capacity coordinate across the sectors
 - Building private capacity to dialogue with MoH and to participate in policy and implementation
- Invest in building PPP/H Node’s capacity to implement PPP/Hs
 - Fully staff and train Node in needed expertise
 - Draft PPP/H implementation guidelines and build operating systems
 - Assist PPP/H Node to generate information on private sector activities

Strategy #5: Broker and Implement in PPP/Hs

- Provide T/A to Node to broke 1st and 2nd generation of PPP/Hs
- Implement low risk/low cost PPPs – coordinate vaccine delivery and coordinate ambulance services, establish public-private referral systems, share information, extend service contracts in select health areas (primary and specialty)

“Low Hanging Fruit”
1 - 2 Years

Strategy #1: Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
- Strengthen private sector reporting to the MoH
- Assist MoH and professional associations/NMOs use data to inform policy, programs
- Streamline and institutionalize SQIS
- Build MoH capacity to interpret and report on status of quality in private sector
- Assist MoH and professional associations/NMOs to use data to improve quality
- Separate and build HRH policy and planning function in the MoH
 - Improve HRIS
 - Strengthen and harmonize professional associations
 - Streamline and strengthen regulatory agencies and councils
- Move towards 3rd party co-regulation of quality
 - Convey legal authority to NMOs
 - MoH and NMOs work together to establish roles/responsibilities and operating systems; conduct joint visits

Strategy #2: Create financial incentives to attract private sector to partner with MoH

- Create institutional arrangements/operating systems for provider payment mechanisms
- Build Node’s capacity to apply tools (e.g. contracting, RBF, vouchers, etc.) in various PPP/Hs

Strategy #3: Reduce economic barriers

- Design and roll-out DBP
- Adapt MH voucher for urban setting, include CH in benefit packages and roll out to urban poor
- Use financial mechanisms to organize and structure private sector in key health markets
 - Compel private providers and private pharmacies/drug shops to join a NMO
 - Provide TA to NMOs to become viable and financially sustainable network managers

Strategy #4: Build public/private capacity in PPP/Hs

- Intensify dialogue and interactions between the sectors
 - Build gov’t entities dialogue and partnering skills
 - Build private sector capacity to unify the private health sector voice
 - Establish PPP/H Coordinating Committees at the District Level
- Invest in building PPP/H Node’s capacity to implement PPP/Hs
 - Train and mentor Node staff skill areas as they broker PPP/Hs
 - PPP/H Node continues to generate data to inform policy and planning

Strategy #5: Broker and Implement in PPP/Hs

- Implement moderate risk/medium costs PPPs – Service contracts with provider NMOs for Urban Poor MH Voucher and pharmacy NMOs under DBP, Down-referral PPP/H for HIV/AIDs, purchase commitments to locally manufacture ORS/ZINC/fortified food, co-location of private lab, outsource non-clinical services

Strategy #1: Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
 - Continue strengthening private sector reporting to the MoH and assisting MoH and professional associations/NMOs to use data to inform policy and programs
- Streamline and institutionalize SQIS
 - Continue strengthening MoH capacity to analyze and report on status of quality in private sector and assisting MoH and professional associations/NMOs to use data to improve quality
- Continue to strengthen MoH HRH policy and planning function in the MoH
- MoH and NMOs work together to monitor quality in private sector

Strategy #2: Create financial incentives to attract private sector to partner with MoH

- MoH has fully functioning institutions and operating systems for provider payment mechanisms
- MoH uses financial mechanisms to further organize and structure private sector
 - All PPP/H compel private providers and private pharmacies/drug shops to join a
 - Support NMOs to manage government contracts

Strategy #3: Reduce economic barriers

- MoH scales DBP nationwide
- MoH scales RBF to purchase services and goods from PNFP and PHPs
- MoH move MCH voucher program management to Ugandan institutions

Strategy #4: Build public/private capacity in PPP/Hs

- Foster opportunities for PPD and coordination
 - Support PPP/H Node to convene various policy forums, mobilize private sector in policy and planning and coordinate public-private resources
- Support PPP/H Node, as needed, to implement complex PPP/Hs

Strategy #5: Broker and Implement in PPP/Hs

- Build on experience with moderate risk/medium costs PPPs to implement high risk/cost infrastructure and MES PPPs – Increase # of service contracts to outsource non-clinical services; Expand # of service contracts with provider NMOs to scale MCH Voucher Program and pharmacy NMOs under DBPs to scale nationwide; Increase # of down-referral contracts for HIV/AIDs and expand to NCDs; Expand # of private lab co-location in MoH facilities; Lease medical equipment/ambulances; Implement a MES for limited # of Neo-Natal Units and Operating Theatres and # of infrastructure PPP to manufacture oxygen and/or establish a national EMRS

1. INTRODUCTION

Uganda’s Vision 2040 proposes a vision of “A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 Years”. It aims to move the country from a low-income country with per capita income of US \$ 506 in 2010 to a competitive upper middle-income country with per capita income US \$ 9,500 by 2040 (Uganda Vision 2040).

Many Ugandans envision a country in which all its citizens can enjoy a productive life with gainful employment, access to education and the right to quality healthcare. Although Uganda is one of the fastest growing economies (4.8%) in East- and Sub-Saharan Africa (SSA), there is still a large percentage (29%) of the Ugandan workforce that are not fully employed in the formal sector (Ministry of Finance, Planning and Economic Development [MoFPED], 2016⁵). Most (69%) of the population still rely on subsistence agriculture to make a living. As a result, the average Ugandan struggles to make ends meet with an average annual income per capita income at US \$570 in 2014 compared to the average in SSA at approximately to US \$1,500 in the same year (World Bank, 2016). There is great income disparity among the Uganda population - as measured by a GINI coefficient of 0.4 - estimates 19.7% of the population lives below the poverty level (Uganda Demographic Health Survey [UDHS] 2011).

Further, Uganda’s health system faces many challenges as shown by selected key development indicators in Table 1.1. Rapid population growth fueled by a high total fertility rate of 6.2 per 1,000 women (UDHS, 2011) continues to strain the current health system with increasing demand for health services. Although life expectancy has increased to its current levels of 57.8 years, it is still lower than the average of 59.5 years in SSA (World Bank, 2015). Child and maternal mortality remain high at 550 per 100,000 live births and 343 per 100,000 live births, respectively. Uganda also has one of the highest HIV/AIDS prevalence rates on the continent, estimated at 7.3% in 2011 (Uganda AIDS Commission [UAC], 2015). With Uganda’s extensive health challenges, making Vision 2040 a reality will require a collaborative health system that capitalizes on the resources and abilities of *all* health system actors.

Table 1.1: Key Development Indicators, Uganda/SSA

Indicator	Data Source	Uganda	Year	SSA Average	Year
GDP per capita (constant 2005 US\$)	WDI-2015	435.0	2014	2029.7	2014
GDP growth (annual Percent)	WDI-2015	4.8	2014	4.7	2014
Adult literacy	WDI-2015	70.0	2012	59.0	2012
Labour participation rates	WDI-2015	75.0	2014	72.0	2014
GINI index (World Bank estimate)	WDI-2015	42.4	2012	42.2	2011
Per capita THE at international dollar rates	WDI-2015	59.1	2013	136.0	2013
Life expectancy at birth, total (years)	WDI-2015	57.8	2013	59.5	2013
Maternal mortality (per 100,000 live births)	WDI-2015	343.0	2015	310.0	2015
Under 5 mortality (per 1,000 live births)	WDI-2015	55.0	2015	85.0	2014
HIV/AIDS prevalence rate	UAC-2015	7.3	2013	4.7	2014

Source: World Development Indicators (WDI): World Bank Indicators Database, UAC, 2015

⁵ MoFPED, Background to the Budget, 2016/17

Against this background, the United States Agency for International Development (USAID) commissioned the USAID/Uganda Private Health Support Program (herein referred to as the Program) to conduct an assessment of the private health sector in Uganda. The Program is well positioned to carry out this technical task as USAID’s private sector flagship program. The Program is designed to leverage the private sector’s strengths while addressing long-standing concerns about its capacity, quality, and interests. The Program aims to strengthen, organize and mobilize the private sector to provide Ugandans with the option of obtaining high-quality health services from private-for-profit (PFP) providers.

Other development partners who joined USAID’s initiative to conduct the PSA in Uganda include the World Bank Group’s Health in Africa Initiative and the Global Financing Facility (GFF). They both committed funds to support the PSA.

1.1. Stewardship of the PSA

One of the PSA’s principles guiding the assessment process is stakeholder involvement. Early on, the PSA team formed a technical advisory committee (herein referred to as Advisory Committee or the Committee) to shape the PSA’s technical scope, identify key stakeholder interviewees and to guide the consultative process to validate the PSAs’ findings and foster buy-in for its recommendations. The Ministry of Health’s (MoH) Commissioner chaired the committee and selected public and private sector representatives to participate (See Annex I for the Committee’s composition and scope of work). The following terms of reference emerged from the Advisory Committee’s deliberations and agreement (See Annex II for the final PSA scope of work).

1.2. Rationale

As Table 1.2 indicates, the PSA can play an instrumental role in generating sound data on the private health sector to inform government and donor programming, guide MoH policy and planning, and design a “blue print” to harness private sector resources and potential to help Uganda achieve universal health coverage (UHC).

Table 1.2 Rationale of Conducting a Private Sector Assessment in Uganda

<p>To generate and consolidate data on private sector activities into a single document for country planning by government and donors</p> <ul style="list-style-type: none"> • To better understand the relevance of the private sector in the health system • To identify gaps in the health system and establish the ideal qualities of a health system • To guide private sector contribution in provision of healthcare • To help inform resource allocation when it comes to private sector • To benchmark, measure progress and evaluate MoH initiatives with the private sector

1.3. Objectives

The PSA’s primary objectives are three-fold:

- To document and develop a comprehensive understanding of private sector activities throughout the health system in Uganda.
- To identify potential areas for the Ugandan private health sector to contribute to MoH’s goal and objectives as outlined in Health Sector Development Plan (HSDP) 2015/16-2019/20.
- To propose a road map to harness private sector potential to address a select number of strategic health areas and/or health systems gaps as outlined in the MoH Public-Private-Partnership Policy and Strategy.

1.4. Scope of PSA

The Advisory Committee met in December 2015 to discuss and agree on the technical and geographic areas examined in the PSA (See Table 1.3). The group preferred, funding permitted, to do a comprehensive scope both in terms of health issues and health system areas as well as geographic reach. The guiding principles were agreed as a comprehensive scope bounded with health priority areas and health policies, and framed by the Sustainable Development Goals (SDGs).

In terms of health issues, the group proposed the PSA examine the health areas outlined according to the World Health Organization (WHO) health system building blocks, emphasizing maternal/reproductive health, newborn/child health, and HIV/AIDS. Health financing and medical supplies were identified as priority areas. Although the Advisory Committee wanted to include other “building blocks” and health areas, the team agreed to ask a few questions but not have a comprehensive analysis of human resources for health (HRH), health management information systems (HMIS), and chronic diseases. In addition, the Advisory Committee recommended the PSA cover the entire country to determine the difference between urban and rural areas in market reach of the private sector.

The Advisory Committee initially identified the following technical areas to be examined in the PSA:

- Policies supporting and governance of private health sector
- Health financing issues as they relate to private health sector
- Size and scope of private health supply chain
- Private sector delivery of key health services, including HIV/AIDS, maternal health, family planning and reproductive health (FP/RH).

Table 1.3 Scope of Private Sector Assessment

- Geographic focus – sample size to represent variations in the country and reflect variance in urban and rural areas.
- Technical focus: Health systems areas as outlined in WHO health systems building blocks – health financing, HRH, medical supplies, leadership and governance, service delivery.
- Health domains/areas – MoH minimum health care package.

1.5. PSA Team

A key feature of the PSA exercise has been the high degree of involvement by MoH, development partners and implementing partners. The PSA team comprised of technical staff from the USAID Private Health Support Program (herein referred to as the Program), GFF initiative as well as MoH Directorate of Planning and Development staff (See Annex III). The MoH staff participated in every aspect of the 5-step process, including participating in the stakeholder interviews and field visits, data analysis, recommendation formulation and dissemination activities. Furthermore, several implementing partners, such as the USAID/ IntraHealth CAPACITY project and all four medical bureaus, helped the team by providing access to data and in some cases, helped perform data analysis featured in this report.

1.6. Outcomes

The Advisory Committee expects the following outcomes from the consultative process to draft the PSA:

- Local capacity to analyze data on the private health sector and to develop strategies informed by international experiences on how to harness the private sector role to contribute to public health objectives
- Government recognition of the private sector current contribution to health and identification of strategic areas to further leverage its potential; and

- Widespread support among both key public and private stakeholder groups to work together on the “Blue Print for Action”.

1.7. Methodology

The PSA team proposed to adopt the approach developed by USAID called “Assessment to Action”. As Figure 1.1 shows, a private health sector assessment consists of five steps: Plan, Collect Data, Analyze the Data, Validate the Findings and Act on Recommendations. A detailed description of the activities and timeline are in Annex IV. The entire PSA process in Uganda emphasized collaboration and engagement with local stakeholders in order to ensure accuracy and buy-in for the key findings and recommendations.

Figure 1.1 Steps in a Private Health Sector Assessment



Source: <http://assessment-action.net/>

Step One: Plan and Organize. The PSA team formed an Advisory Committee and convened its first meeting in December 2015. The Advisory Committee helped finalize the PSA technical scope as well as identify key documents for the literature review. The Advisory Committee also finalized the technical composition of the PSA team based on the technical scope and facilitated some of the stakeholder interviews. The Advisory Committee also played active roles in data collection and analysis, confirmation of the PSA’s findings and recommendations in addition to organizing and leadership at the PSA validation workshop in June 2016.

Step Two: Learn through Data Collection. To better understand the current political, economic, and social landscape in Uganda, the PSA team began with a literature review of gray literature (i.e. unpublished reports and government materials), published key policy documents, and previous studies on the private health sector and public-private partnership (PPP) arrangements in Uganda.

In addition, the PSA team conducted a secondary analysis of past surveys – including the past three Demographic and Health Surveys (DHS), Health Service Provision Assessment (SPA 2007) and National Health Accounts (NHA) report - as well as the District Health Information System (DHIS 2).

Following the literature review, the PSA team conducted stakeholder interviews to fill information gaps and to gauge stakeholders’ interest in and willingness to engage in public-private dialogue (PPD). The assessment used a representative sample of stakeholder from the whole country, ensuring urban-rural representation.

The sample was taken from five regions of the country, i) Kampala Metropolitan, ii) Central 1 and 2, iii) East and Central, iv) West and South West, and v) North and West Nile.

Using a key informant interview guide that focused on each of the WHO health system building blocks, the assessment team interviewed a broad range of representatives from the public, private-not-for-profit (PNFP), and private-for-profit (PFP) health sectors. In each region, two districts were sampled. In each district, the team interviewed the District Health Officer (DHO), the Public-Private Partnership Focal Person and staff from at least 5 private-not-for-profit (PNFP) facilities, 5 private-for-profit (PFP) facilities and 5 retail pharmacies and/or drug stores. Approximately 30-35 people were interviewed in each district. In addition, the team interviewed central level stakeholders from the Kampala Metropolitan Region in the public sector ranging from top-level officials to mid-level managers in the MoH, professional health councils and Ministry of Finance, Planning and Economic

Development (MoFPED). On the private sector side, stakeholders included professional associations, trade associations, and individual private providers from a sample representing a wide range of health facilities and supply chain operations. Donors and their implementing partners rounded out the stakeholder interviews. More private providers and their representative bodies were interviewed compared to those from the public sector.

The team conducted stakeholder interviews over a 3-month period beginning in January 2016. First, the PSA team conducted all the Kampala Capital City Authority (KCCA) related interviews in the first two weeks of January. Subsequently, the PSA team traveled to eight regions, following the geographic division used in the UDHS: Central 1, Central 2, East, East Central, West, South West, West Nile and the Northern Region. The PSA team interviewed over 173 individuals from approximately 90 different organizations as detailed in the map and list of all stakeholders interviewed by sector (Annex V).

Step Three: Analyze the Data. The analysis began concurrently with data collection beginning in January, 2016. Through routine debriefings, the PSA team shared information, vetted initial findings, and began to form actionable recommendations. The PSA team held two consultative meetings in January: the first was with the Public Private Partnership in Health (PPPH) Node and the second was with the PSA Advisory Committee to present a first-cut outline of findings, priorities, and recommendations. While drafting the report, the PSA team had back and forth consultations amongst themselves as well as key public and private stakeholders for additional information and clarification.

The PSA team carried out quantitative secondary data analysis on DHIS 2 data and on past survey data mainly using *STATA* and *Microsoft Excel* software. For qualitative data, stakeholder interviews were recorded, data transcribed and analyzed to determine key themes related to private sector engagement and its contribution to the health system.

Step Four: Validate the Findings. The Advisory Committee played an active role in i) reviewing and commenting on the first draft report; ii) strategizing on how to disseminate the preliminary findings among key stakeholders in both the public and private sectors to build support; and iii) brainstorming on recommendations and developing the blue print for action. In addition, the Advisory Committee convened a consultative meeting with public and private key stakeholders halfway through the process in May 2016. Over 40 stakeholders participated in this meeting to discuss the PSA's first draft and to plan for the dissemination events in June 2016. Later, the Advisory Committee offered comments on the PSA's preliminary draft and presented the finds at the East African Healthcare Federation Conference in Kampala in June 2016. Thereafter, the Advisory Committee convened a meeting in July 2016 with a larger group of stakeholders to provide comments and prioritize the recommendations. Further, after compilation of the final draft, a series of regional dissemination and validation workshops were carried out in Mbale for the Eastern, Gulu for Northern, Masaka for Central and Mbarara for Western and South-Western in October and November 2017.

Step Five: Act on the PSA Recommendations. The Advisory Committee agreed to repurpose the PPPH TWG to steward the PSA’s recommendations and to monitor implementation of the suggested “Private Sector Blue Print” (See Annex VI). In October 2016, the PPP TWG convened its first of many consultative meetings in which the participants drafted the framework for the PPPH Strategy. The participants referred to the PSA for many policy and PPP recommendations.

1.8. Organization of the PSA Report

This report is organized into ten sections.

- **Section 1** introduces the PSA, giving its scope, objectives, methodology and expected outcomes.
- **Section 2** gives a contextual background to PPPs and describes the key segments of the private health sector including its size and distribution in Uganda. The PSA also offers a new perspective – the landscape of the health system in which all public and private sector actors are mapped in the mixed health system.
- **Section 3** focuses on the policy environment and market conditions supporting the private sector’s role in Uganda’s goal to achieve UHC. This section also discusses the MoH stewardship of the private sector, policies enabling or hindering the private sector and market conditions.
- **Section 4** analyzes trends in public and private financing of health and the different mechanisms currently used to mobilize sector resources to deliver health services and products.
- **Section 5** analyzes the dynamics in accessing financing of health services in the private sector.
- **Section 6** presents the size and contribution of the private health sector in delivering essential health services critical to achieving UHC. Selected areas of focus are HIV/AIDS and maternal and reproductive health.
- **Section 7** focuses on the private sector’s delivery of essential medicines, health supplies and diagnostic services and participation in key aspects of pharmaceutical supply, such as manufacturing, distribution and retail.
- **Section 8** focuses on private sector delivery of laboratory services.
- **Section 9** examines the role of the private sector in producing and employing human resources for health.
- **Section 10: Annexes**

2. OVERVIEW OF THE UGANDAN MIXED HEALTH SYSTEM AND THE PRIVATE SECTOR CONTRIBUTION

One of the objectives of the PSA is to present a comprehensive picture of the various players contributing to the Ugandan health system. This section sets the stage for the PSA by reframing the vision of the health system to recognize the mixed delivery and financing of health care in Uganda. In this section, the PSA defines the public-private mix of health care delivery and the respective actors in the health sector, describes the different segments of the Ugandan private sector and provides key facts that explain the private sector's contribution to the health system.

2.1. Reframing the Policy Approach: Government with, not versus the Market

All too often, when we discuss health systems and health sector reform, the international health community tends to fall along two ideological camps (Soderlund et al, 2003). The first one believes that government control and provision of health services and products is the best approach to ensure citizens' right to health and UHC. While the second camp believes that a greater private sector role – that is, a more market approach – will deliver better results at a lower cost. This dualist approach is similar to the classic policy discourse found in many countries worldwide – “state control” and “market fundamentalist”. In the “state control” model, the government's role is to correct market failures and the government is needed to make the market system operate efficiently. The “market fundamentalist” model, on the other hand, sees the market economy as self-organizing and uncontrollable. By definition, this model believes the government is trying to do the impossible – control markets – and therefore the state should stay out of the economy. However, this simplistic – yet common – policy framing only creates a deadlock, offers no solution or way forward, and can result in both the government and the market losing credibility and legitimacy among the population (Colandar, D. and Kupers, R. 2014).

This polarized policy discourse – *free market and versus government control* – or in the case of the health system – *public versus private health sector* – is a limited framing to analyze the dynamics in a health system. First and foremost, the health system in any given country is just that, a complex system comprised of multiple actors many of whom are non-state. Complex systems are dynamic, adaptive and continually evolve over time (Colandar, D. and Kupers, R. 2014). A complex system's fundamental nature does not allow for either government control or for a self-steering market without a government role. As a result, this ***dichotomy gives us the “wrong compass” by which to guide a health system***. If we look for solutions through this dual framework, then we will not capture the diversity of stakeholders in the health sector and the interplay that drives a complex health system. Moreover, this framing fails to acknowledge the interconnected nature of the problems in a health system (Colandar, D. and Kupers, R. 2014).

2.1.1 Growing Recognition of Mixed Delivery System

Colander and Kupers suggest a complex system framework to analyze the health and other economic sectors. A complex system frame focuses on the dynamic interplay between key stakeholders and their respective roles, and how both state and non-state actors co-exist and co-evolve in a system. In this framework, a complex system frame is neither “market” nor “government” and acknowledges that there is no market independent of each other. Instead, it is a complex system in which the ***government is with, not versus the market*** (Colandar, D. and Kupers, R. 2014). Translated into the health system, it would be ***government plus private sector***.

Global health management appears to be undergoing a gradual shift in focus away from diseases towards systems (Nista, 2010). This is partly a response to the difficulties that disease-specific global health initiatives have experienced in meeting individual program targets and internationally agreed benchmarks, in spite of significant increases in development assistance over the past decade. The private health sector's place within a health system, particularly in low and middle-income countries, is changing and generally expanding due to this shift in focus. Governments are deliberately promoting private providers, acknowledging their *de facto* role in an increasingly pluralistic health system to address a country's health challenges and funding constraints (Soderlund et al, 2003).

2.1.2 Management of a Mixed Delivery System

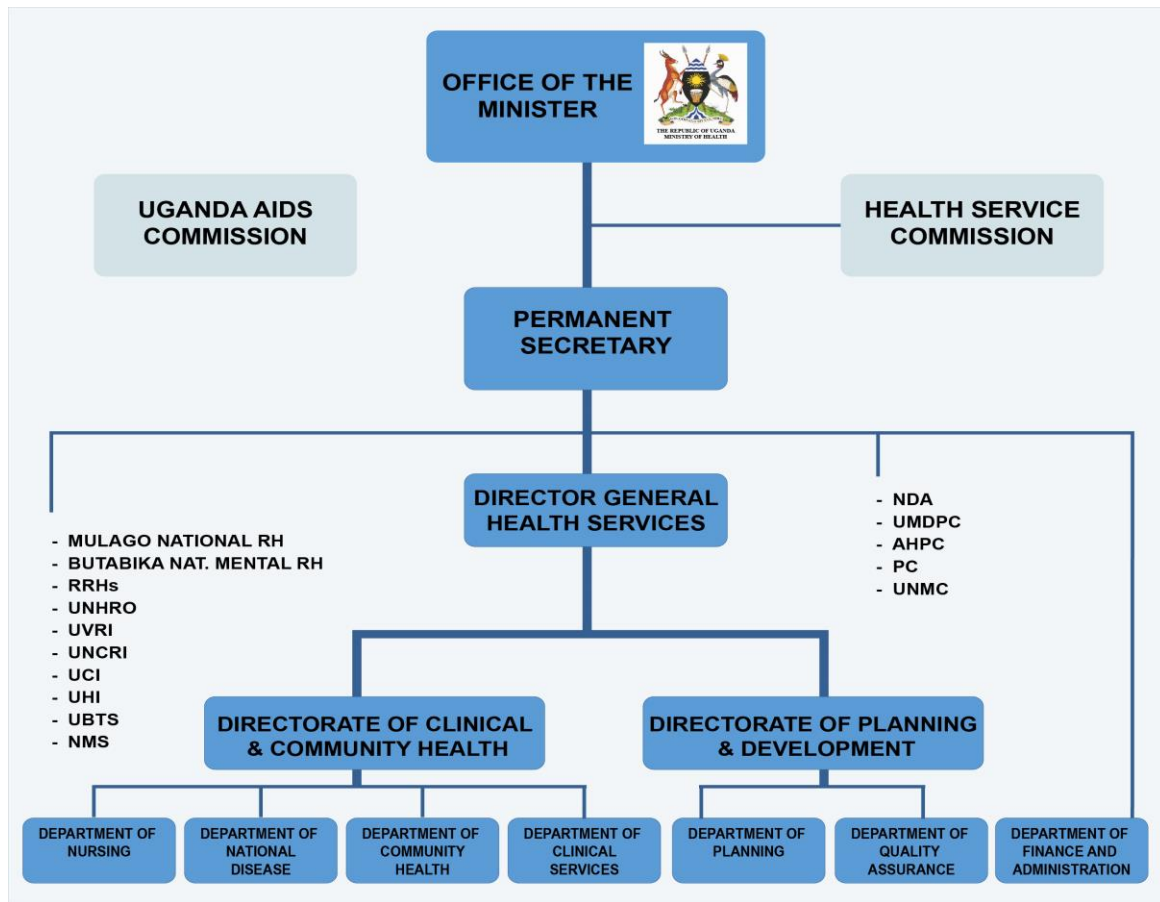
Managing the public/private mix in health care is a difficult task and always the government's responsibility (Soderlund et al, 2003). Under this reframing, government policy is still crucial for a complex system to work and ***government still plays an important role in a health system's evolution***. Under a standard government control approach, government is outside a system correcting it for market failures in health. Under a market fundamentalist approach, government gets out of the way of the health market. However, in a complex system, government can and does play an important role in influencing and shaping the system but can neither dictate nor control it. Salaman argues for this ***guiding approach*** because i) public problems have become too complex for governments to handle on their own, ii) there is disagreement on the right policy approach, and iii) government is losing legitimacy and authority if they do not give non-state actors a seat at the policy table (Salaman, L. 2002).

Although government is just another institution in a complex system, ***it is a very special kind of institution and often the central player***, whether it chooses to play that role or not (Howlett, M. and Rosch, M. 2014). Governments are imbued with particular properties (power to influence and set the rules) that no other stakeholder has in the health sector. Moreover, private markets cannot be relied on to give appropriate weight to public interests over private ones without active government involvement (Salaman, L. 2002). Even in a more pluralistic governance arrangement, the implementation process needs to be steered towards constructive, positive coordination. As Colander, D. and Kupers note, *"A well-functioning market is the consequence of previous and successful government policy. When the market works well, one of the important reasons it is successful is that the government has laid the groundwork for it to be successful"* (Colander, D. and Kupers, R. 2014). Therefore, a MoH such as the Ugandan MoH still plays a critical, even protagonist role in shaping health systems and markets.

2.2. Landscape of Uganda's Mixed Delivery Health System

An important product of a PSA is to landscape all the public and private actors to offer a comprehensive illustration of the principal groups operating in ***a mixed delivery health system***. Traditionally, most assessments and evaluations of a health sector, as well as government produced health policies and plans, primarily focus on government organizations and public delivery of health services. In the case of Uganda, the private health sector is implied by the PPPH Node in the department of Planning in the MOH macro structure (See Figure 2.1).

Figure 2.1 Uganda Ministry of Health Macrostructure



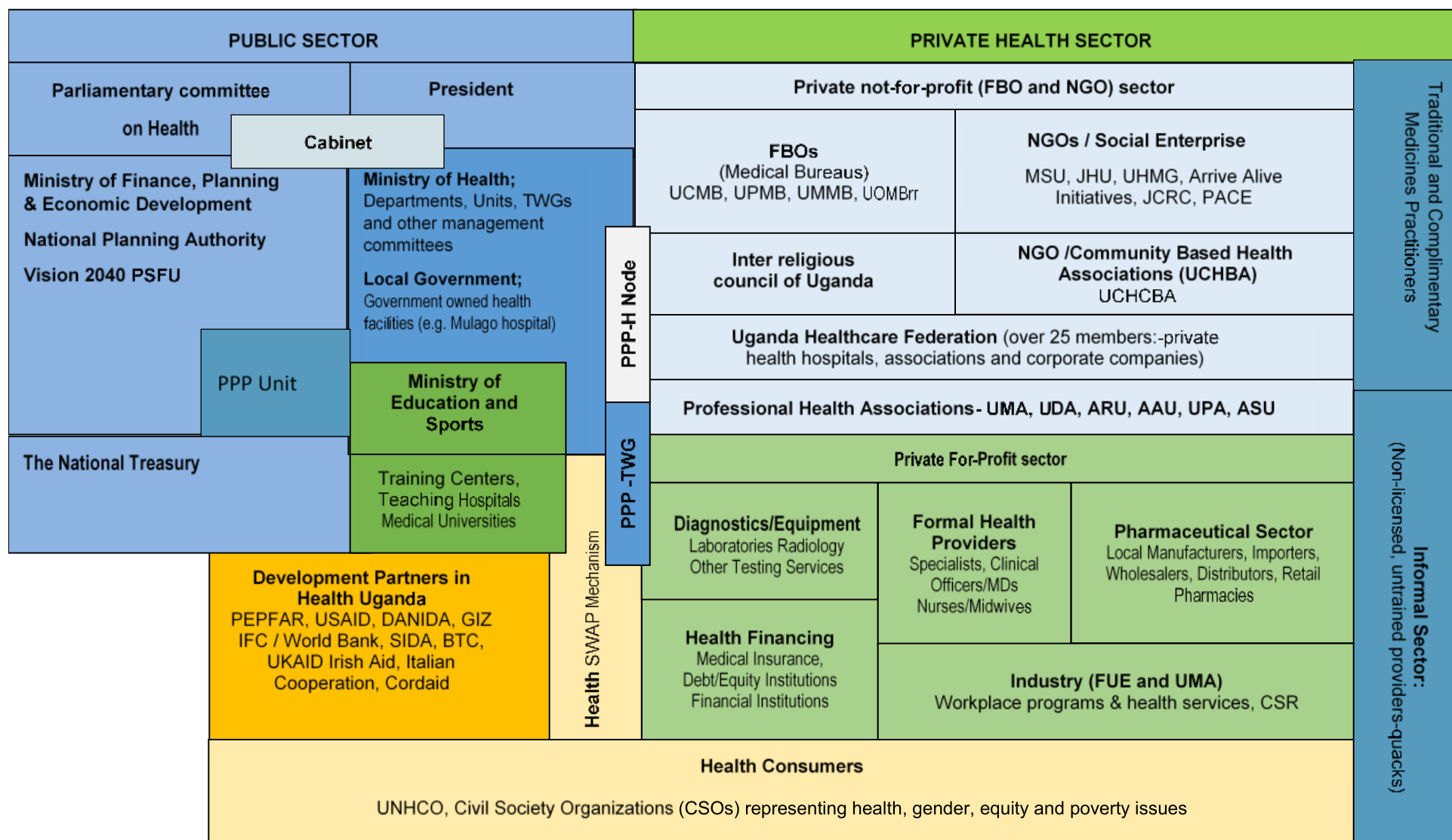
Source: HSDP 2015/16-2019/20

However, there have been increasing efforts to reflect the mixed nature of the Ugandan health sector. Key analyses and planning documents, like the Uganda Health System Assessment (HSA) 2011 and Health Sector Development Plan (HSDP) to name a few, include descriptions and analyses of different PNFP and PFP actors. The PSA aims to build on these analyses and to strengthen it with new data and information on *all public and private* activities in health by producing a landscape of Ugandan health sector (See Figure 2.2).

The health system landscape is organized into six segments – or groupings – of health stakeholders: (i) government sector, (ii) development partners and their implementing agencies, (iii) private-not-for-profit (PNFP), (iv) private-for-profit (PFP), (v) civil society, and (vi) informal health sector including Traditional and Complementary Medicine Practitioners (TCMP). Although not exhaustive, this figure illustrates the diverse range of actors as well as development partners and underscores the complexity of the Ugandan health system and challenges confronting the MoH in its lead role and responsibility of guiding the entire health sector.

The private health sector in Uganda is varied and diverse. It is therefore important to define the private health sector to help interpret the PSA findings. In an attempt to capture the wide range of private health sector actors – both in the formal and informal provision of health services – the Public Private Partnership in Health Policy (PPPH Policy) organizes the private health sector into three categories: PNFP, PHP, and TCMP. The PNFP sector is divided into two categories: i) Facility-based PNFP also referred to as Faith Based Organizations (FBOs), which have a significant network of health. The FBOs are well organized into four medical bureaus affiliated with their respective religion; ii) Non-facility-based PNFP, which is less structured, comprised of hundreds of international and national NGOs as well as community-based organization (CBOs).

Figure 2.2 Current Landscape of Uganda Health Sector Structure



Source: Updated from the PHS Program 2013 Stakeholder Analysis

The landscape above highlights several points about the Ugandan health sector:

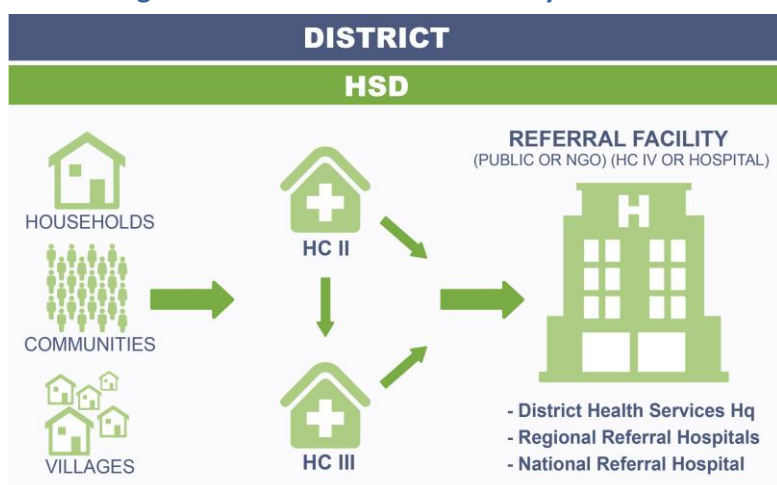
- Government sector operations in health is more than just the MoH, particularly with the push to decentralize health decision-making and service delivery to the district levels;
- The private health sector is diverse and still somewhat fragmented;
- Civil society has yet to find its voice to represent the consumer perspective on health;
- Development partners play an instrumental role, both in terms of resources and technical assistance, in the health sector; and
- The informal health sector operates mostly outside of the law.

2.2.1 Public Sector

The government is the leading actor in the Ugandan health system with a wide range of government entities ranging from the Executive Branch (the Office of the President), Legislative Branch (Parliament and the Parliamentary Health Committee) and various line agencies. The primary actor in the public sector responsible for health is the MoH, with support from other government agencies such as the National Treasury and Ministries of Finance, Planning and Economic Development (MoFPED), Education and Sports (MoES) and Local Government (MoLG) that support the MoH in varying capacities and activities. In addition to MoH health facilities, there are also public health facilities under the Ministries of Defense (Army), Internal Affairs (Police and Prisons), and MoLG. The MoH provides leadership for the entire health sector as well as delivers health services and other public health functions, such as quality assurance, disease surveillance and public health education to name a few.

The National Health Policy (NHP) and the 5-year National Health Strategic Plans, which emphasize decentralization of government services including health, largely dictate the Health Sector goals and public sector strategies, roles, and responsibilities. At the national level, the MoH focuses on policy, governance, strategic guidance, development of operational tools and processes, setting of standards and financing of different health actors. MoH also oversees medical research and manages level-three hospitals (national, referral and specialized) and is responsible for coordinating with other relevant ministries, departments, and agencies (MDAs) including the MoFPED for funding support and MoES for medical education. Public health care is organized in a tiered structure that defines the number and type of facilities at different level as shown in Figure 2.3.

Figure 2.3 Structure of the Health System



Source: Health System Profile, 2004

The range of health services varies with the level of care. Level II HCs are the most basic health facility, followed by HCs III, which are similar to polyclinics. HC IVs are primarily small hospital facilities. At the next level are district and national level referral hospitals. Health services have been decentralized with districts and health sub-districts playing a key role in delivering and managing health services, starting with district hospitals and below.

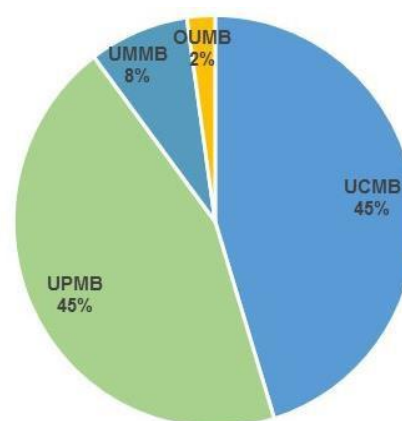
2.2.2 Private Health Sector: Not-for-Profit (PNFP)

Faith-Based Sub-Sector

The Ugandan FBOs have a long history (over 50 years in some cases) and long-standing relationships with the MoH. The FBOs are organized into four major umbrella organizations: i) Uganda Catholic Medical Bureau (UCMB) founded in 1956, ii) Uganda Protestant Medical Bureau (UPMB) founded in 1955, iii) Uganda Muslim Medical Bureau (UMMB) founded in 1998 and iv) Uganda Orthodox Medical Bureau (OUMB) founded in 2009. About 75% of the facility-, based PNFPs are under the four Medical Bureaus management. The bureaus operate 70% of health training institutions and manage the second largest supply chain mechanism in Uganda – Joint Medical Stores (JMS) – founded in 1979 through a partnership between UCMB and UPMB (Orach, 2014).

Figure 2.4 shows the distribution of health facilities among the medical bureaus as presented at the Joint Review Mission in 2014 (Orach 2014). UCMB and UPMB operate the largest number of health facilities: forty-five percent (45%) each. In addition to their coverage and reach through their vast network of health facilities, the FBOs claim that each week, between Friday and Sunday, approximately 15 million people attend a church or mosque (Inter-Religious Council of Uganda [ICRU], 2013) which provides a ready audience and forum for educating and engaging communities on a variety of health, economic and political issues.

Figure 2.4 Distribution of Facilities by Bureau, 2014



Source: Orach, 2014. Presentation to JRM

The FBOs have organized themselves under an umbrella organization – the IRCU – to create a united voice in negotiating budgets, staffing and other important issues related to health service delivery with the government (FBO informant, 2016). The IRCU Council of Presidents, whose responsibility is to provide strategic direction and advice to the organization, has a representative from each of the four major bureaus and is supported by an Executive Board, which provides oversight on implementation of IRCU policies and programs. The Secretariat is the management component of the IRCU and has two directorates, one focused on HIV/AIDS and the other Public Health.

Each bureau owns and manages its own health facilities, but most of them were built in the early missionary years – sixty to eighty years ago, and are in need of repair. However, FBOs continue to handle a high volume of clients and provide quality services, especially in rural areas where access to health service is limited. Table 2.1 shows that the majority of FBO facilities are mainly HC III and HC II facilities.

Table 2.1 PNFP Health Facilities by Bureau and by Level, 2014

Bureau	Hospitals	HC IV	HC III	HC II	Total
UCMB	32	5	176	77	290
UPMB	18	8	56	207	289
UMMB	5	2	22	21	50
OUMB	1	1	3	11	16
Subtotal	56	16	257	316	645

Source: PNFP Sub-sector Report 2015

FBOs depend on a variety of sources to finance their activities (See Box 2.1). The MoH subsidizes PNFPs at around 20% of total revenue according to a PNFP key informant. PNFPs also charge user fees as a strategy to raise funds and depend on donors to finance a significant percentage (33%) of their activities (Orach, 2014). Funding continues to be a major concern for the FBOs, creating a potential risk for the health system if they cannot meet demands with their limited funding base (see Section 4 for more discussion on health financing). To strengthen their position in the health sector, the four medical bureaus jointly negotiate funding levels and other subsidies with the MoH. The FBOs signed memorandums of understanding (MOUs) with the GOU in order to strengthen the partnership and collaboration between them regarding health service delivery in Uganda. The collaboration also extends to intra-collaboration (IRCU, 2013).

2.2.3 Non-Facility-Based PNFPs

The non-facility-based PNFPs are diverse and less structured compared to the FBOs. They are comprised of non-government organizations (NGOs) and community-based organizations (CBOs). NGOs provide mainly preventive health services including health education, counseling, and promotion, while CBOs offer community mobilization and development, community health, environmental conservation, and advocacy.

Some FBOs also have non-facility based organizations that carry out similar functions as the NGOs and CBOs. Many of these organizations rely on donor funds to respond to HIV/AIDS and other pressing health priorities like malaria, maternal and child health, tuberculosis and family planning. The diversity makes it challenging for MoH to partner with this sub-sector of the health system.

In addition to the PNFPs, a myriad of health professional associations has emerged in response to the need to organize and advocate on behalf of the diverse range of health workers in the sector. There are over 25 registered associations. In some cases, like the Uganda Medical Association (UMA), the professional organization represents health professionals from both the public and private health sectors while other associations, like the Uganda Private Medical Practitioners' Association (UPMPA), cater only for private professionals (See Table 2.2). To address this fragmentation, the Uganda Health Federation has emerged as an umbrella organization that brings all these different associations to a common forum (see Box 2.2)

Table 2.2 Health Associations in Uganda

Name	Name	Name
Uganda Medical Association	Uganda Pharmaceutical Manufacturer's Association	Pharmaceutical Society of Uganda
Uganda Dental Association	Uganda Pharmaceutical Distributors' Association	Uganda Clinical Officers Association
Association of Radiologists of Uganda	Association of Uganda Women Medical Doctors	Uganda Insurers' Association
Uganda Pediatric Association	Uganda Association of Allied Health Professionals	Uganda Community Based Health Financing Association
Uganda Private Midwives' Association	Uganda National Association of Community and Occupational Health	Uganda Radiographers Association
Uganda Private Medical Practitioners' Association	Islamic Medical Association of Uganda	Uganda Society for Advancement of Radiology and Imaging

Box 2.1 Source of Revenue for Key FBOs

UPMB

- User fees
- Government contributions
- Small membership fees from facilities
- Donors - CDC is their biggest partner followed by Bread for Life
- Income generating activities like real estate and eye clinic

UCMB

- User fees
- Government contribution (10%)
- Donors- 60-80% from global initiatives for HIV/AIDS, TB, Malaria of which 80% of these monies is directed to HIV/AIDS,
- Individual support for capital development
- Service level incomes

Name	Name	Name
Association of Anesthesiologists of Uganda	Association of Obstetricians and Gynecologists of Uganda	Health Management Organizations' Association
Association of Surgeons of Uganda	National Cancer Awareness Association	Uganda Private Health Units Association
Association of Physicians of Uganda	Uganda National Health Researchers Association	Uganda Nurses and Midwives' Union
Uganda National Association of Private Hospitals	Facility Based Health Plan Association	Uganda Community Based Health Care Association
Federation of Private Health Professionals Association		

Source: Uganda Healthcare Federation Recruitment Strategy, 2016

Box 2.2 Private Sector Efforts to Unify their Voice: Uganda Healthcare Federation

Uganda Healthcare Federation (UHF) is an umbrella body, established to champion the interests of the private health sector. UHF is an affiliate of the East Africa Healthcare Federation, with sister federations in Kenya, Tanzania, Burundi, Ethiopia, South Sudan and Rwanda.

UHF is an association of associations, with a membership of over 55 non-state health related associations and organizations in Uganda. These include medical service providers, health professionals/ HRH, health facilities, distributors and manufacturers, mHealth innovators, traditional and complimentary medicine groups, as well as health civil society partners.

UHF uniquely integrates contract and program activities into the grassroots for impactful and sustainable results, through inclusion of its member associations in implementation processes. The organization promotes private health sector cohesion and development through monthly networking events, an e-newsletter and tailored health business management training. It also offers training in Health Consumer Rights based on the Ministry of Health 2009 Patients Charter for meaningful results in achieving patient centered care and plays an integral role in the roll out of the Self-Regulatory Quality Improvement System (SQIS), a toolkit focused on improving service delivery quality standards in private health facilities. Simultaneously UHF has introduced the Safecare stepwise quality improvement system in private health facilities.

With such a vast and heterogeneous non-state health sector, UHF offers government, health development partners and health sector stakeholders an informed health sector partner, through which to disseminate information interface and engage with the private health sector. UHF in turn, is the private health sectors mouthpiece, lobbying and advocating for affordable, accessible quality health, through various platforms and forums.

2.2.4 Private Health Sector: Private Health Providers (PHP)

The formal private health providers include a comprehensive range of professionals who are trained in health care provision, including physicians, nurse/midwives, and clinical officers. They provide services for profit through small clinics and polyclinics and/or group practices that offer high-end, specialty care (See Figure 2.5).

The Health Facility Inventory, 2012 indicates that the PHP own and operate 28% of all health facilities in Uganda (see Table 2.4). As of 2010, it was estimated that the PHPs constitute 22.5 % of all health care providers in Uganda. This sector is growing at a moderate pace, with most practitioners located in urban centers.

Almost 70% of the privately-owned facilities are located in the Central Region with Kampala District alone accounting for 45% of the PHPs (PHR 2005).

These PHP facilities range from large, modern hospitals in Kampala, to small clinics and doctor offices in private practice. Figure 2.6 shows that few PHPs own or operate HC IVs (See Figure 2.6). The MoH estimates there were only 7 PHP-owned hospitals in 2005 and they increased to 23 in 2012 (see Table 2.3). The share of privately owned hospitals in the country, therefore, increased from 7% to 15% in the same period. Stakeholders interviewed state that rise in the private health sector has been driven by wealthier persons in Kampala (PHR, 2005).

The majority of the PHP facilities are small and singly owned, mostly by a medical doctor or a midwife/nurse. In 2005, the average PHP facility employed nine staff, while 70% of the clinics had a medical doctor (PHR, 2005). The same study found that more than 80% of the doctors working in the private sector were employed within the Central Region and half of the doctors working in the private sector also worked in the government sector. Further, more than 90% of private sector nurses, midwives, and nursing aides worked full-time in the private sector and the estimated number of staff employed in the PHP sector nationwide was 12,775.

Most privately-owned clinics are at the level of HC II, i.e. stand-alone facility with preventive and outpatient services. PHPs provide an array of health services. The small facilities offer limited services for a low cost, while some are large well-equipped hospitals in Kampala with advanced tertiary care and high user-fees. The PHR study found that PHPs offered mostly curative services whereas preventive services were more limited. The exception is family planning, which was offered by three-quarters of PHP facilities. One fourth of the PHPs surveyed in 2005 provided inpatient services. More than 90% of PHP facilities treated malaria and sexually transmitted diseases, but only 22% offered immunization services. About 40% of the PHPs provided maternity, post-abortion care, and adolescent reproductive health services.

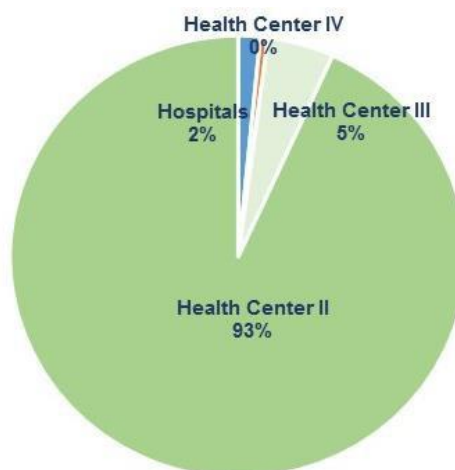
Difficulties in accessing capital and other incentives have limited the development of certain aspects of service delivery in the private sector. PHP clinics for example, offer less HIV/AIDS services than public facilities, mainly due to the fact that donors mostly fund HIV/AIDS programs through the public sector. However, the contribution of private sector entities is more marked in clinical support services such as diagnostics and laboratories and supply chain management.

Figure 2.5 Formal and Informal Private Sector Actors in Health



Source: PHS Program, 2013

Figure 2.6 PHP Facilities by Level



Source: Uganda Health Facility Inventory, 2012

The private sector supports the medical supply chain and includes pharmaceutical entities such as international research and development pharmaceutical companies, importers, distributors, manufacturers and retail pharmacies (see Section 7 for more details on private sector role in Essential Medicines, Health Supplies, and Medical Laboratories).

Finally, there are two other private sector actors that play important roles financing health care. First, there are major employers and industries in Uganda whose core business is not health related but who provide healthcare services to their employees and the communities in which they operate through company owned clinics and/or health insurance programs.

There is a small, but growing, number of private health insurance and micro-financing institutions in Uganda that finance health services and medicines not only in the private sector but also in the public sector (See Section 4.4 for more information on private health insurance).

2.2.5 Private Health Sector: Traditional and Complementary Medicine Practitioners

In addition to the formal private providers illustrated in Figure 2.5, the health system also has Traditional and Complementary Medicine Practitioners (TCMPs) who are mostly informal, unlicensed providers. The MoH recognizes this group in an attempt to better monitor their activities and to ensure they comply with quality and safety standards, but despite the MoH's efforts, their regulation still remains a challenge in Uganda. The Uganda PPPH Policy 2013 recognizes the role of Traditional Medicine has in the health care delivery system. This policy defines traditional medicine to include "locally and traditionally available diverse health care practices incorporating plant, animal, and/or mineral-based medicines to treat, diagnose or prevent illness." TCMP are comprised of practitioners of Chinese and Ayurvedic medicine, herbalists, traditional bonesetters, traditional birth attendants, hydro-therapists, spiritualists, and traditional dentists. In Uganda, it is estimated that approximately 60% of the population seek care from a TCMP before and after visiting the formal sector (HSSIP 2010/11-2014/15). The poor rely heavily on a TCMP because they are much more widely available and accessible and is often the only affordable source of health care. The traditional practitioners in Uganda have mobilized themselves under The National Council of Traditional Healers and Herbalists Associations of Uganda.

A number of institutions and organizations are involved in researching TCM development, application, and practice. Within the national research system, Natural Chemotherapeutics Research Laboratory (NCRL) is spearheading research in traditional medicine and medicinal plants. Makerere University, the National Agricultural Research Organization (NARO) and Mbarara University of Science and Technology are also key research organizations in this field. The Uganda National Council for Science and Technology provides overall coordination in all aspects of science and technology research in this area.

2.2.6 Civil Society Organizations

Several Civil society organizations (CSOs) at the national level are engaged in policy deliberation and health programming and planning. The Uganda National Health Consumers Organization (UNHCO) and the Coalition for Health Promotion and Social Development HEPS-Uganda are two CSOs that independently monitor community level health programs' performance. UNHCO also advocates for the health consumer rights and educates communities on their rights and responsibilities. They have also persuaded the MoH to include indicators measuring consumer satisfaction and developed the Patient's Rights Charter, specifically the Client Satisfaction Index in the HSDP 2015–16 - 2019/20. HEPS-Uganda conducts studies at the community level to assess access of essential medicines and advocates for improved supply of affordable drugs. Key issues raised by CSOs during the PSA key informant interviews include:

- Greater access to health services for marginalized or underserved population groups (e.g. disabled, women and children, post-conflict Northern Uganda);
- De-stigmatization of HIV/AIDS, better treatment of AIDS patients and access to affordable, quality ARVs; and
- Better transparency and accountability of government budgets and programs.

The media also plays an important role as a member of civil society. Major newspapers often dedicate space for health-related information (HSA, 2011) such as HIV/AIDS, malaria, and tuberculosis (TB). Corruption and malpractice receive a fair amount of coverage as well. Talk shows have become a popular medium for citizens to discuss and contribute to topical issues regarding health. Research on media coverage show that the press and media are not well informed or lack accurate data to report on health topics, creating misinformation (HSA, 2011).

2.2.7 Development Partners

There are many development partners involved in health (see Table 2.3). USAID is the largest donor, accounting for forty-nine percent (49%) of all donor funds directed to Uganda. The majority of development partner projects are focused in strengthening health services, and more specifically HIV/AIDS and TB. Of the twenty-five listed projects, fourteen fund HIV/AIDS, malaria and TB projects through the (US) President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund for TB, AIDS and Malaria (GFTAM). Child health is the next largest area of donor support, mainly with GAVI funds. There is a mix of donors supporting family planning and reproductive health including the World Bank, Swedish International Development Cooperation Agency (SIDA) and USAID. The fewest number of development partner programs is in the area of health system strengthening of which the majority focus on infrastructure. For more detailed information on their areas of focus, refer to Annex VIII.

Table 2.3: Overview of Development Partners Projects

Technical Area	Development Partner	Specific Interventions	Geographical Coverage in country
Child health	GAVI	<ul style="list-style-type: none"> • Donate vaccines and equipment • Conduct campaigns and immunize 91% of all children 	All
HIV/AIDS	MILDMAY	<ul style="list-style-type: none"> • Increase demand for HIV and TB prevention, care, and treatment services • Deliver quality HIV and TB services 	Central, West Nile
HIV/AIDS	PHS	<ul style="list-style-type: none"> • Increase access to HIV care and treatment services through private health providers (PHPs) • Improve the quality of HIV and SMC services provided by PHPs 	All
HIV/AIDS	NUMAT	<ul style="list-style-type: none"> • Strengthen district management of the decentralized health system • Support the delivery of HIV and AIDS care and treatment services • Enhance quality of care • Support increased stewardship by the MOH and various hospitals to sustain service delivery 	Northern
HIV/AIDS	STAR-E		Eastern
HIV/AIDS	STAR-EC		East Central
HIV/AIDS	STAR-SW		SW
HIV/AIDS	SUSTAIN		Central, South Western, Western
HIV/AIDS	Walter Reed	<ul style="list-style-type: none"> • Vaccine development • Build vaccine testing capability in Uganda • Conduct epidemiological and basic research and provision of HIV Treatment, care, and support • Support surveillance of influenza and other emerging infections 	Central

Technical Area	Development Partner	Specific Interventions	Geographical Coverage in country
Health System Strengthening	SDS	<ul style="list-style-type: none"> Supports local governments to improve social service delivery Focuses on health, education, and services for OVCs 	35 districts in Eastern, Western, Central
Infrastructure	AfDB	<ul style="list-style-type: none"> Upgrade Mulago Hospital Purchase ambulances to strengthen referrals in KCCA 	
Infrastructure	Islamic Development Bank	<ul style="list-style-type: none"> Construct new maternity hospital 	N/A
Infrastructure	World Bank UHSSP	<ul style="list-style-type: none"> Upgrade 2 GH (Moroto and Mityana) RHs Rehabilitate GH, maternity wards, and HCs Purchase medical equipment and ambulances 	All
Infrastructure	JICA West	<ul style="list-style-type: none"> Rehabilitation for RRHs Purchase equipment for RRH 	Kabale & Hoima RRH
Infrastructure	Italian Support	<ul style="list-style-type: none"> Construct staff housing 	Karamoja
Malaria	GFTAM	<ul style="list-style-type: none"> Scale of rapid diagnostic tests 	All
Malaria	IRS-2	<ul style="list-style-type: none"> Carry out IRS in all communities 	North
Malaria	PMI, GFTAM DFID World Vision	<ul style="list-style-type: none"> Train health workers in effective malaria case management Prevent malaria through universal coverage of LLNs Make ACTs accessible and affordable 	Central, Eastern, Western
Malaria	Stop Malaria		All
Medicines	Securing Ugandans Rights to Essential Medicines (SURE)	<ul style="list-style-type: none"> Support on-the-job training on medicine management activities in MoH facilities 	All
RH	World Bank - UHSSP	<ul style="list-style-type: none"> Strengthen MoH capacity to develop and manage Improve MoH management of health services Procure and distribute equipment and EmOC drugs, FP commodities to HC Increase demand for FP through vouchers (West) Carry out community awareness campaigns 	All
Maternal/RH	SIDA	<ul style="list-style-type: none"> Supports PNFP/ NGOs delivering maternal and perinatal care 	N/A
RH	STRIDES-USAID COMPLETED	<ul style="list-style-type: none"> Increase contraceptive use among WRH Strengthen public and private provider FH services Train RRHs to provide routine fistula services 	Central, EC, Eastern, Western
RH	GAVI, Merck	<ul style="list-style-type: none"> Introduce and scale-up HPV vaccine 	
RH	UNFPA	<ul style="list-style-type: none"> Procure ambulances and create systems to manage them Advocacy to build political support for FP/RH services 	Central, Eastern, Western
RH	USAID Voucher	<ul style="list-style-type: none"> Remove economic barrier to maternity/FP services Improve quality of private sector maternity/FP services 	N/A
TB	STOP TB	<ul style="list-style-type: none"> Increase DOT of TB coverage Scale-up multi-drug resistant TB treatment to RRHS 	Mbarara, Mbale, Gulu and Fort Portal

Sources: AHSPR 2014/2015, NHA 2011/12, donor websites

2.3. Numbers Describing the Public-Private Mix Delivery System

For a variety of reasons, the private sector role in the Ugandan health sector is not well acknowledged. Factors contributing to this under appreciation include MoH’s limited understanding of the private health sector, underreporting by the private health sector to the MoH, as well as limited interactions and poor communication between the two sectors. Despite these challenges, the private stakeholders interviewed believe that the private sector makes a significant contribution to the Ugandan health sector (see Box 2.3) and the data in the sections below confirms this assertion.

2.3.1 Public-Private Mix of Health Infrastructure

Table 2.4 illustrates the overall growth in the total number of health facilities in the Uganda health system as well as the dramatic growth of the PFP sector between 2005 and 2012. According to the MoH, the total number of health facilities almost doubled during this period from 2,731 to 5,229. All three sectors (public, PNFP and PHP) experienced growth in the number of health facilities they own and manage. Public facilities grew by 50%, while PNFP grew by 45%, but the PFP sector exploded during this time increasing by 500% from 277 to 1,488 facilities. Although there was growth in all facility levels, the most dramatic growth occurred in HC IIs and IIIs.

Box 2.3 Perceived Private Health Sector Contributions

- Increasing cohesion between different cadres of health care providers in Uganda
- Strengthening private health sector organizations and institutions
- Improving the overall health care management in Uganda
- Creating demand for health products and services

Source: Key Informants Professional Associations

Table 2.4 Number of health facilities by type and ownership 2005-2012

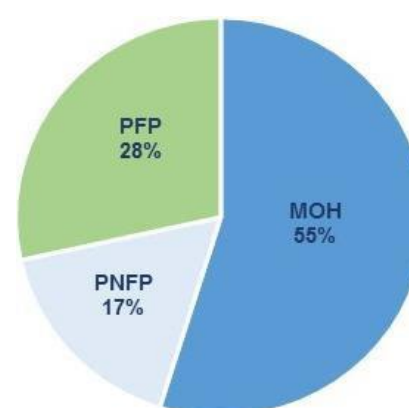
Facility Level	Public		PNFP		PHP		Total	
	2005	2012	2005	2012	2005	2012	2005	2012
Hospitals	56	64	45	65	7	23	108	152
HC IV	148	170	9	15	3	8	160	193
HC III	706	937	157	272	10	70	873	1,279
HC II	945	1,696	391	522	257	1,387	1,593	3,605
Sub-Total	1,855	2867	602	874	277	1,488	2,734	5,229

Source: Health System Profile 2005 and Uganda Health Facility Inventory 2012

MoH’s 2012 Health Facility Inventory shows there are approximately 5,229 health facilities in Uganda (Table 2.3). The public sector owns and operates more than half (55%) of all health facilities in Uganda (Figure 2.7). The private health sector – both PNFP and PFP – own and manage 45%, a considerable percentage of all health facilities in Uganda. The PFP own more facilities than the PNFP - 28% and 17% respectively.

In examining the type of facilities, the PNFPs have a more balanced portfolio of health infrastructure compared to the PFPs. The PNFPs have as many hospitals as the public sector and similarly, most of their facilities are HC II and III (Table 2.5). As noted before, most PFPs facilities are HCs and clinics.

Figure 2.7 Total Number of Ugandan Health Facilities by Ownership, 2012



Source: Uganda Health Facility Inventory, 2012

Stakeholder interviews noted that many public and FBO health facilities are over burdened with excess demand for services yet there are PHP health facilities nearby with adequate capacity. They expressed a need for better rationalization and coordination of services between the sectors to relieve the congestion in these high-volume facilities, avoiding the need for the MoH and FBOs to invest in building new facilities (MoH and PHP stakeholder interviews, 2016).

2.3.2 Distribution of Public-Private Facilities

The MoH policy aims at ensuring UHC to all Ugandans, and geographical coverage is a step towards this. Although there is considerable infrastructure in both the public and private health sectors, the distribution of health facilities is highly inequitable. Data from the HSDP 2015/16 - 2019/20 indicates that only 72% of the population currently lives within 5-km of a public health facility. This is an improvement since an earlier study indicated that only 48% of the Uganda population lived within a 5-km radius of a public or PNFP facility (Orem et al, 2010).

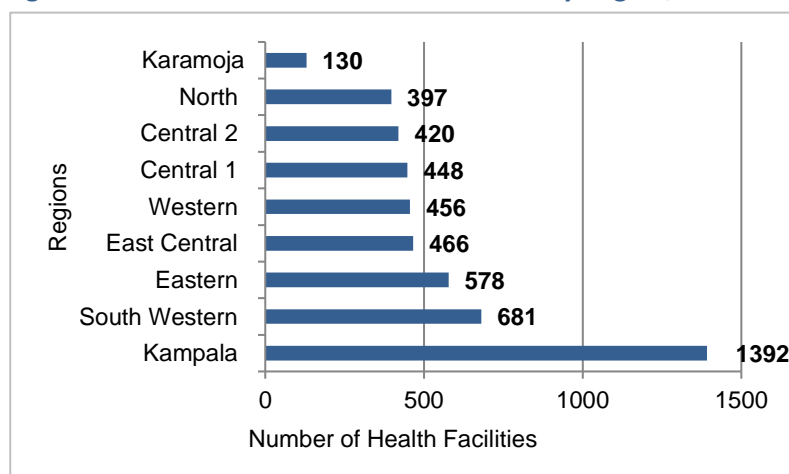
The study also indicated that there is variation in access depending on the type and owner of health facility. Only 11% of the population live within 5-km radius of a public hospital and 23% and 49% within reach of a HC and a private clinic respectively. Distribution of hospitals is not equitable either: some districts (e.g. Kampala) have several public, PNFP and PFP hospitals while others have none.

Moreover, access is restricted by functionality of these facilities. Even though there may be a public health facility, it can be non-operational because of staffing shortages, broken equipment and drug stock-outs. According to the Health Service Provision Assessment in Uganda study (MoH, 2014) only 13% of health facilities in the country reported having the full stock of medications, tests, and medical equipment recommended for the provision of ante-natal care (ANC), while 8% of health centers, across all levels, and clinics had malaria diagnostics but lacked Artemisinin-based treatment (ACT), suggesting that ACT stock-outs may not be uncommon among these platforms. Another study reported that 33% of general hospitals, 52% of HC IV and 44% are not fully functional (Orem, 2010).

These findings show the fragmentation and inefficiencies in the health system that could be addressed through policy change towards contracting services to the private sector and rationalizing services. Access may increase considerably if the MoH would start integrating and planning with PHPs.

Using the data from the 2012 MoH health facility inventory, the following series of graphs illustrate the regions (based on UDHS clusters) with the most public, PNFP and PFP health facilities. Almost one-third of Uganda’s health facilities are located in the Kampala region (Figure 2.7).

Figure 2.8: Total Number of Health Facilities by Region, 2012. N=5,229

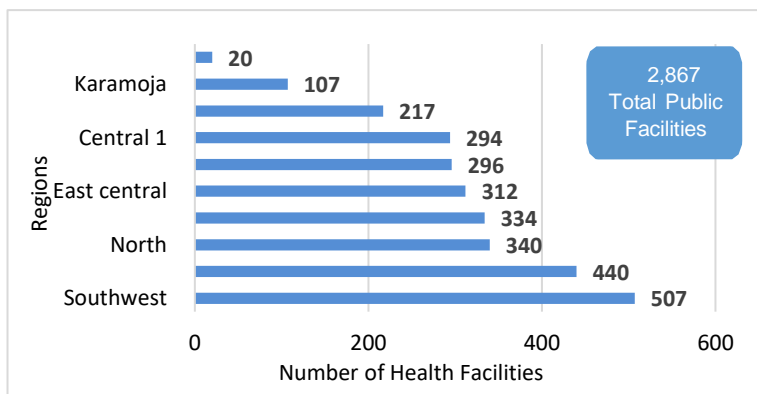


Source: Health Facility Inventory, 2012

Kampala has more than double the number of health facilities from the two other regions with the largest number of health facilities – South West and Eastern.

The poorest regions, Karamoja, West Nile and the North, have the least number of health facilities.

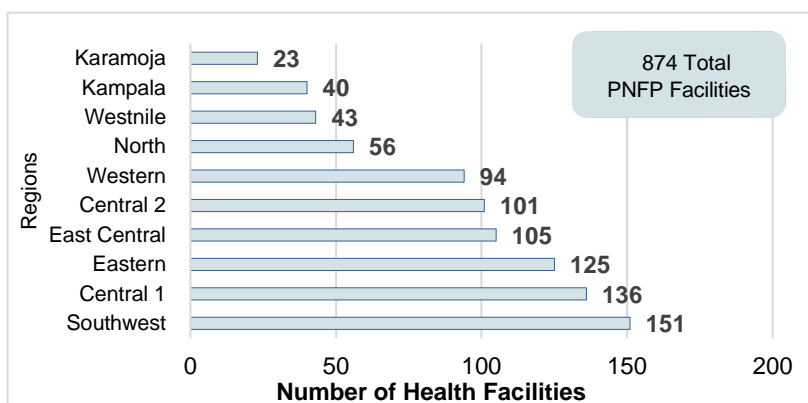
Figure 2.9: Total Number of Public Facilities by Region, 2012



South West, Eastern and the North Regions have the highest number of public health facilities.

Source: Health Facility Inventory, 2012

Figure 2.10: Total Number of PNFP Facilities by Region, 2012

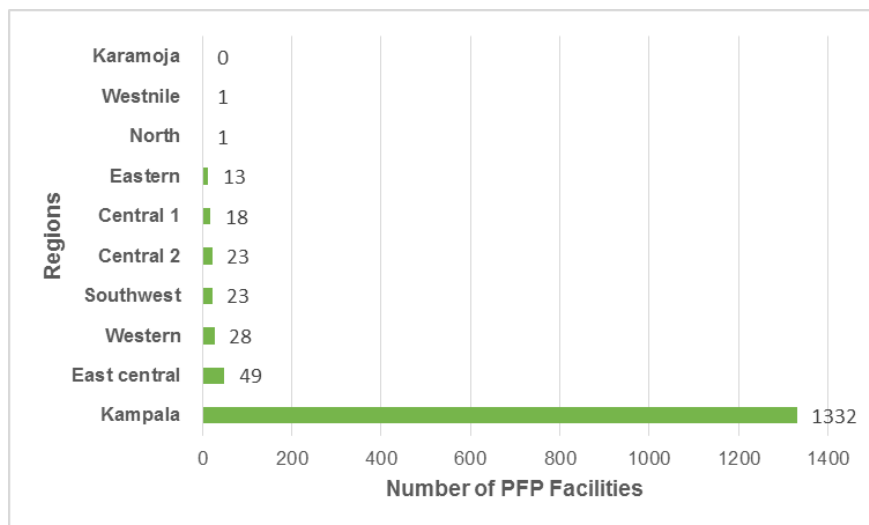


South West, Central 1 and Eastern have the most PNFP facilities. There is a considerable overlap of public and PNFP facilities in the same regions.

Source: Health Facility Inventory, 2012

Figure 2.11: Total Number of PFP Facilities by Region, 2012

Almost all of the PFP facilities are concentrated in Kampala that has a limited number of public and PNFP facilities.



Source: Health facility Inventory, 2012

Given the distribution of health facilities and the population of the different regions, there is room to better coordinate and rationalize health service delivery between the three major providers of health care in Uganda’s mixed delivery system.

2.3.3 Public-Private Mix of Health Personnel

The PSA team found inconsistencies in the data on health workers between different government sources. Specifically : i) the MoH does not collect data on PHPs, ii) data collected is fragmented and located in several different MoH agencies, iii) the PHPs under-reports to the DHIS 2, and iv) there is double counting due to dual practice. The numbers presented in this section are a best estimate, underscoring the need for the MoH to collect consistent data on all HRH irrespective of where they work and the urgent need to standardize the data collection on HRH.

Although data for formal health workers in the private sector is not complete, one can see common trends in the distribution of health cadres who work in the private health sector (Table 2.5).

Table 2.5 Health Cadres by Workplace

HRH Category	Total	Public	PNFP	PHP	Private Sector %
Doctors	5,141	1,047	361	3,733	80%
Nurses	28,885	16,490	4,145	8,250	43%
Midwives	12,115	10,465	987	663	17%
Clinical Officers	6,685	2,702	558	3,425	60%
Laboratory staff	8,926	2,447	746	5,733	73%
Anesthetic Cadre	359	238	147	-	38%
Pharmacists	657	45	24	588	93%
Dispensers	551	169	172	210	69%
Other allied staff	6,205	3,295	382	2,528	47%
Total Available	67,237	35,248	7,522	24,467	47%

Sources: Public sector data adapted from MoH HRH Audit Report 2011, PFP and PNFP data adapted from Professional Councils’ databases, PNFP websites, Uganda Healthcare Directory 2013-2014 and UPMA data

About half (48%) of the **total** health workforce are employed in a PHP and PNFP facility. The majority of doctors (80%) work in the PHP sector, and these doctors are both general practitioners and specialists such as surgeons, gynecologists, pediatricians, orthopedic surgeons, dentists, Ear Nose and Throat specialists, sonographers, and radiologists. Similarly, the majority of allied health providers work in the private sector - clinical officers (60%), pharmacists (93%) and dispensers (69%). In contrast, a lower percentage of number of nurses (43%) and midwives (17%) are employed in the private sector. Of the nurses working in the private sector, double the number works in the PFP sector compared to those in the PNFP sector (8,250 and 4,145, respectively). The stakeholder interviews as well as research indicate there is a significant percentage of dual practice in most health cadres (Mandelli A. et al. 2005). For example, according to a 2005 study, , 54% of the doctors working in the private sector also work in the government sector.

2.3.4 Public-Private Mix of Health Training Institutions

Uganda, like many other low and middle-income country, is grappling with HRH shortages that affect quality of care through reduced staff levels, lack of critical skills and heightened service delivery burdens on the existing workforce. The role of the private sector in regard to health training institutions cannot be down played. Both PNFP and PHPs together own 72% of all health training institutions (HTIs) as detailed in Table 2.6.

Table 2.6 Medical Training Institutions by Ownership (2015)

Type	Status	MOH	PNFP	PFP	Total
Nurse/Midwifery	Registered	14	7	6	27
	Licensed	0	19	30	49
	Not registered, not licensed	0	0	3	3
	Subtotal	14	26	39	79
Allied Health Professions	Registered	22	2	6	30
	Licensed	0	7	19	26
	Not registered, not licensed	0	0	3	3
	Subtotal	22	9	28	59
University Medical Schools	Registered / Licensed	4	0	1	5
TOTAL		40	35	68	143

Source: MoES/CAPACITY Project. Inventory of health training institutions, 2015

The private sector is the biggest operator of nurse/midwifery schools in Uganda (Figure 2.10). Out of the 79 nursing and midwifery HTIs, the MoH owns 18%, while the PNFP sector owns 33% and PFP 49% (USAID/CAPACITY program, 2015). The private sector is also an important contributor in training the allied health professions - it owns about two thirds (63%) of all Allied HTIs compared to the public sector (37%). One out of the five university medical schools is a PHP institution. Stakeholder interviews revealed that better coordination between all the health training institutions by the respective Ministries (MoH and MoES) has helped the country produce the number and types of HRH urgently needed in Uganda’s mixed health delivery system.

Figure 2.12 Public-Private Mix of Nurse/Midwifery

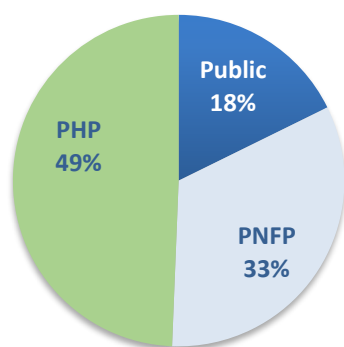
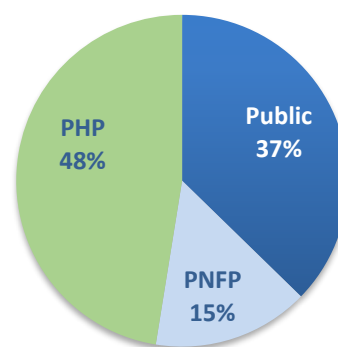


Figure 2.13 Public-Private Mix of Allied HTIs



Source: Capacity Program, 2015

2.4. Key Findings

2.4.1 Uganda’s Mixed Delivery System Requires Change in MoH’s Governance Structure

Increasingly, health care in both the Organization for Economic Co-operation and Development (OECD) as well as low and middle-income countries (LMIC) is delivered in a mixed health system (WHO Bulletin, 2010). Coordinating the relationships between public and private providers is therefore essential to developing an effective health system (Soderlund et al, 2003). Government no longer delivers health services alone and subsequent sections show that private sector role varies depending on sub-sector and/or health market.

As the private health sector grows in Uganda, the need to regulate, manage and coordinate *all* actors in the health system is becoming increasingly apparent.

Many LMICs governments like Uganda have limited experience in managing a public/private delivery system. In many of these countries, health care was initially delivered through a public system and the policy framework, regulatory systems and governance structures were appropriate for a health system with public health providers only. Over time and as more non-state actors enter into different health markets, these same policies and regulations as well as regulatory bodies have become progressively out-of-date and are no longer applicable for a mixed and complex health system.

2.4.2 Private Sector is Active in all Aspects of the Uganda Health System

Figure 2.14: Private Health Sector Entities Organized by WHO Building Blocks



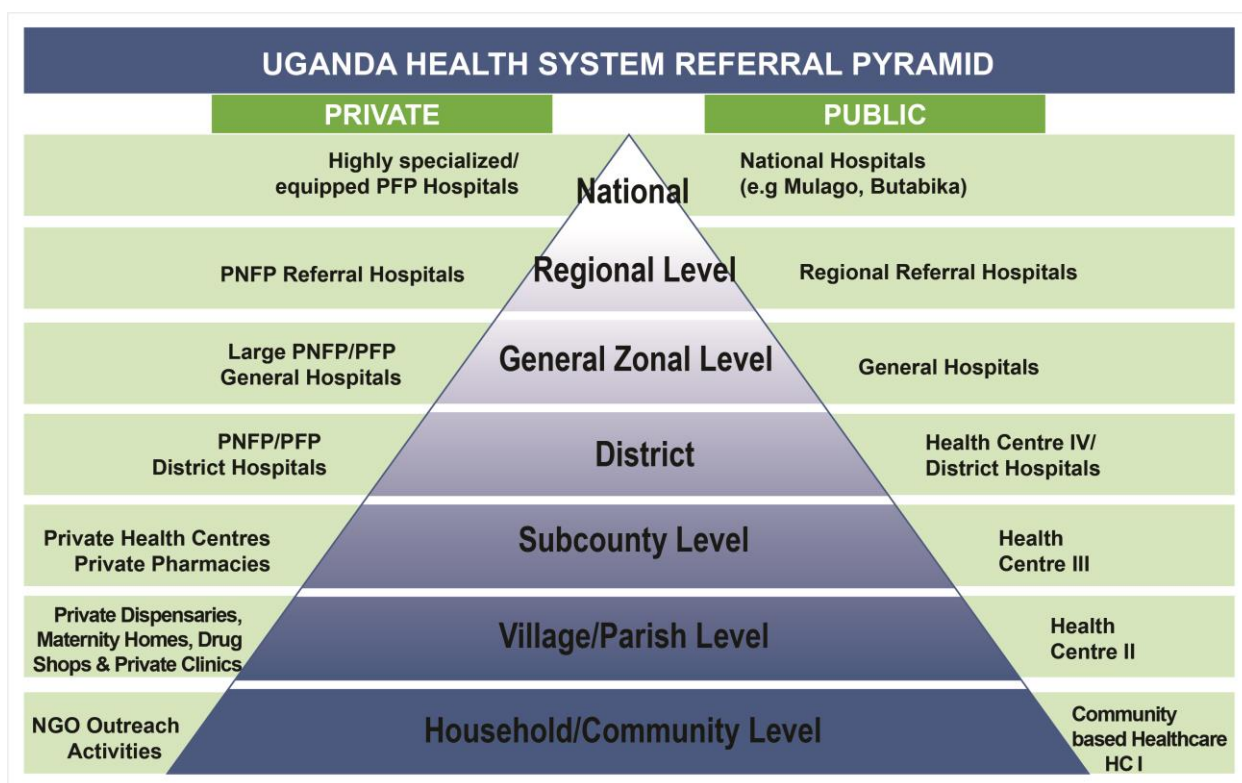
Source: SHOPS Project, 2012

Policymakers often focus solely on the private sector's role in healthcare delivery yet this sector in Uganda is active in all aspects of the health system as Figure 2.14 illustrates. NGO networks, health professional associations and umbrella organizations engage the MoH on policy and planning issues. Academic Institutions, Think Tanks and Market Research Organizations as well as private Information Communication Technology firms also play important roles in gathering health information. Albeit on a limited scale, private health insurance, community based financing and microfinance institutions are helping finance healthcare. PFP and PNFP medical training schools for different health cadres are stepping in to assist government medical colleges and teaching hospitals meet the growing demand for education and training of healthcare professionals. Increasingly, both the PFP and PNFP sectors are creating alternative supply chains to address chronic stock-outs of medicines and supplies and establishing laboratory networks to replace inadequate diagnostic equipment in public health facilities.

2.4.3 The Private Sector is Active at all Levels of the Ugandan Health System

Figure 2.15 illustrates the Ugandan Health System Referral Pyramid and shows that there are private health facilities at all levels starting from lower level dispensaries and maternity homes at the village or parish level to high-level specialty and referral hospitals at the regional, zonal⁶ and national levels. It is important to note that in the private sector, particularly the PFP sector, there are a few, highly qualified and skilled healthcare providers and facilities concentrated in urban centers while the majority of PFP providers are solo practitioners operating one-room offices or small clinics scattered throughout the country, especially in rural areas.

Figure 2.15: Uganda Health System Referral Pyramid



Source: USAID/PHS Program 2016

2.4.4 Private Health Facilities are Located throughout Uganda

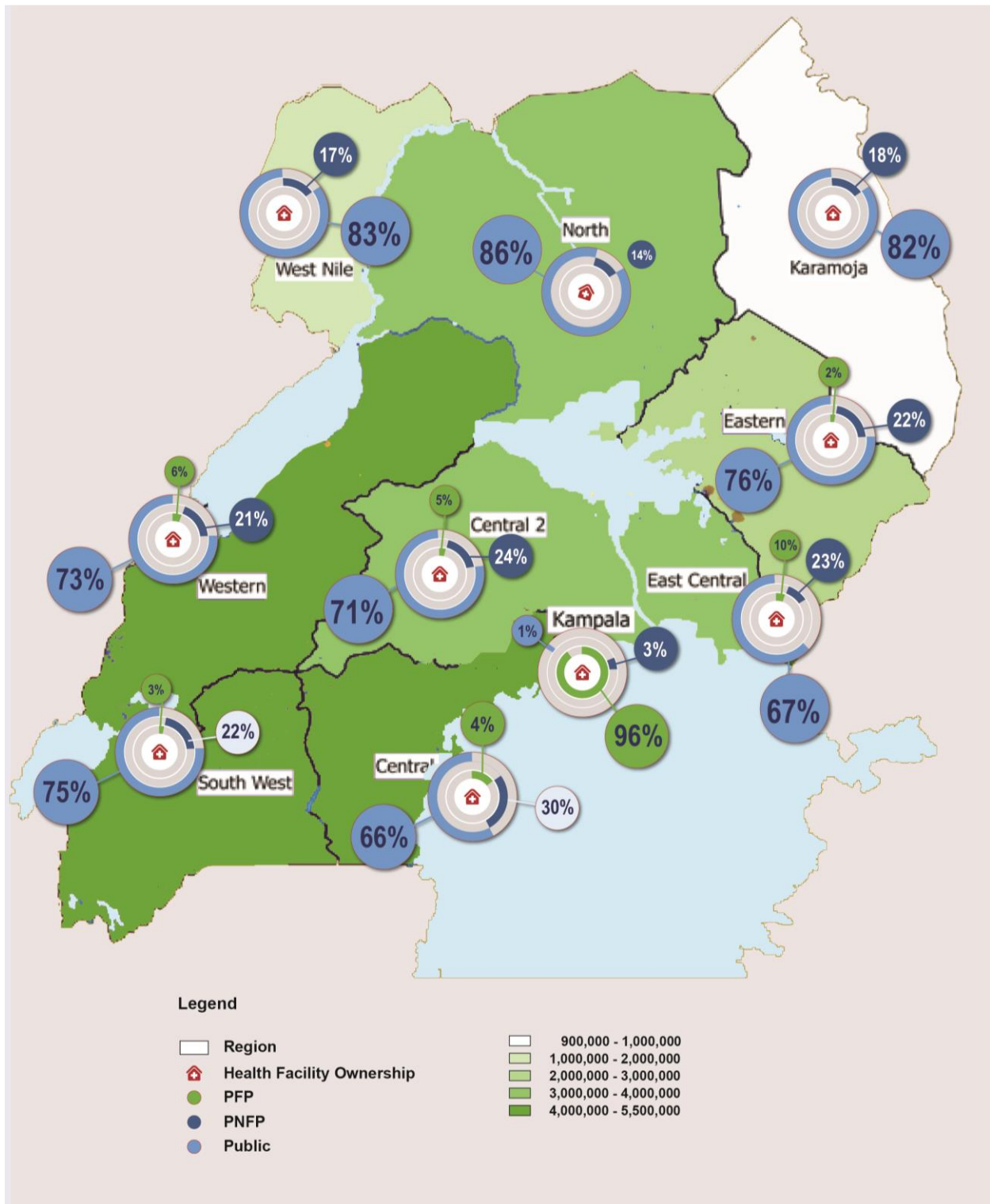
Private health facilities are found in all districts of Uganda albeit in unequal numbers as shown in Figures 2.9. Figure 2.14 illustrates the proportionate distribution of all health facilities by region and by sector⁷. A quick glance of the map shows that:

- **The public sector** is the major owner and operator of health facilities in 8 out of the 9 regions – the sole exception is Kampala;
- PNFP facilities are located mostly outside of the Kampala region;
- **PNFP facilities** are important providers of health services to rural populations in hard to reach regions such as West Nile, the North, and Karamoja;
- **PFP facilities** are mostly found in Kampala and its two closest regions – Central 1 and Central 2 - and the Western Region;
- **PFP facilities** are minimal in the West Nile, North and Karamoja regions.

⁶ FBOs in the PNFP sector have diocesan zones

⁷ See Annex X for a breakdown of all the health facilities by public and private sectors, by facility level and by regions).

Figure 2.16: Public-Private Mix of Ugandan Health Facilities by Regions (2015)



Source: DHIS 2, 2015

Take Home Messages on Public/Private Mix in Uganda's Health System

- **The private health sector in Uganda is active in all segments of the health system.** The private health sector – both PNFP and PHPs – has grown dramatically in the last ten years and has helped contribute to overall growth in health service and product delivery. The Ugandan private sector not only delivers health services, but is also present in all the WHO health system building blocks (e.g. HRH training, supply chain, medicines and technologies, health information and governance).
- **The private health sector size and scope is considerable in Uganda.** Both the PNFP and PHPS own and operate a significant portion - forty-five percent - of all health facilities in Uganda. Moreover, they employ almost half (48%) of all HRH in Uganda, including the majority of physicians, pharmacists and pathologists. The private sector is an important source of HRH production, owning and operating seventy percent of all HTIs. In addition, they are present in all regions throughout Uganda, particularly the PNFPs in rural and remote areas and PHPs in urban areas.
- **The Ugandan MoH still plays a critical, protagonist role in shaping health systems and markets.** The PSA offers a comprehensive landscape of the Ugandan health sector, which is a **mixed delivery health system**. Regulating the public/private mix in health care is a difficult task, which is primarily the government's responsibility.
- **GOU is a special kind of institution and the central player in the mixed health delivery system.** The Uganda MoH is empowered to influence and set the rules for the mixed delivery system; a role no other stakeholder has in the health sector. Moreover, the Ugandan MoH has an important role in ensuring public interests are balanced with private ones throughout the wide range of health markets by “steering” constructive, positive coordination.

3. POLICY ENVIRONMENT SUPPORTING PRIVATE SECTOR CONTRIBUTION TO UHC

3.1. This section focuses on the operating environment for the private sector in health.

There is growing evidence on what factors enable or hinder public private engagement (World Bank, 2011; O’Hanlon, 2013). These factors can be organized into three necessary conditions – often referred to as the “3 Ps” (see Figure 3.1):

- P1-public-private dialogue (PPD)
- P2-public-private interactions; and
- P3-public-private partnership (PPP)

The three conditions are related but not necessarily a step-wise process (Barnes, 2011). For example, successful private sector engagement (PSE) may involve a type of informal interaction and cooperation between the public and private sector (P2), leading to recognition of the need to

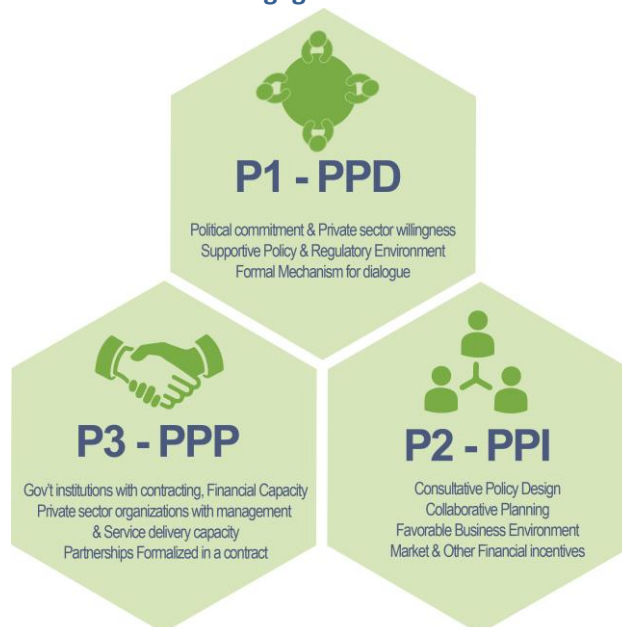
discuss a wider range of issues and to share information on health activities (P1). Similarly, public and private actors coordinate activities but may want to formalize this coordination in a partnership (P3). Irrespective of how the engagement process starts, it is important to note that it is difficult to enter into a health PPP (P3) in the absence of communication (P1) or interaction (P2) between the sectors, building the need for trust in complex and financially risky partnerships. Likewise, it is unlikely that partners will enter into formal agreements (P3) if there has not been some level of cooperation (P2) previously.

Effective mobilization of the private health sector to improve health outcomes and to compliment the Ugandan MoH’s efforts towards UHC requires a policy and operating environment that enables the “3 Ps”. Figure 3.2 displays the range of barriers and enabling factors supporting or hindering private sector engagement. These factors are organized into three categories: Policy Context, Quality of Public-Private Relationship and Market Conditions (discussed in Section 5). As can be expected, if the ledger tips towards a greater number of barriers, then it will be more difficult to engage and collaborate with the private health sector. However, if there are more in the enabling column, then together, these factors can build a foundation of trust on which the public and private sectors can communicate regularly and openly, leading to improved coordination between the sectors. This solid foundation is needed as the Ugandan MoH and private health sector move from informal, contractual arrangements to more complex, costly PPPs. This section further describes the balance between these conditions to determine how conducive the operating environment is for private sector engagement in Uganda.

3.2. Historical Context for Private Sector Engagement

In Uganda, the government has pursued some form of PPPs in health with varying success since pre-independence days (Tashobya, 2006). The earliest recognized form of partnership in health is the relationship between the MoH and facility based PNFP sector dating back to the early 1960s.

Figure 3.1 Factors Supporting Public-Private Engagement



The MoH used the General Notice 245 of 1961 as the policy instrument to provide financial and other support to the voluntary sector as the PNFP was referred to in this period (Tashobya, 2007).

This support However, dwindled and eventually stopped during the crises of the 1970s (Bataringaya and Lochoro 2002). Despite the decreased support, the PNFP sector continued to operate during this turbulent time. PNFPs filled a critical gap during the 1980s and 1990s while public health services deteriorated (Giusti, 2002).

Figure 3.2 Barriers and Enablers to Public-Private Engagement



By the early 1900s, the health sector was increasingly polarized between the public and private health sector with little or no sharing of information and no coordination in planning and development (Kirunga et al, 2006). Although the 1987 Health Policy Review Commission Report recommended integrating the private sector into the national health care system and the 1993 government White Paper on Health Policy highlighted the need for a higher profile for the private sector in health, neither initiatives garnered any political support. It was not until 1996 that this issue actually got on the health policy agenda.

Two factors contributed to private health sector visibility: growing support by MoH leadership to work with the PNFP sector while at the same time a financial crisis hit the PNFP institutions (Tashobya, 2007) creating a trigger point in the relationship between the two sectors. Many PNFP hospitals were about to close because of increased costs, declining financial resources and the bureau's mission to keep user fees affordable for the poor (Kirunga, 2007). In response to the PNFP sector's critical situation and in recognition of their contributions in health in the country, the government decided to provide financial subsidies to the PNFPs. The government's decision to provide support through increasing but limited budgetary support avoided the immediate crisis but also opened the door to wider PNFP participation in health policy and planning (Giusti, 2002) and represented a major step forward in the development of PPPs in the health sector (Kirunga et al, 2006).

Box 3.1 2000s Key Health Sector Reforms

- SWAp Process encouraging development partners to align their support to MoH strategies
- Abolishment of user fees in MoH facilities
- Improved management systems in the areas of finances and drug supply
- Establishment of PPPs in health
- Decentralized service delivery to district governments
- Improved resource allocation dedicated to districts
- Strengthened political leadership from the President, MoH and MoFPED

Despite this long history of interest in PPPs in health, it is only in recent years, particularly since the early 2000s in tandem with other key health system reforms that real progress has been made (see Box 3.1). The government began the process of institutionalizing PPPs in health with the appointment of the NGO health sector panel, which was assigned the role of formulating methods for collaboration between the government and the private sector. The government integrated the Panel's recommendations into the first National Health Policy (1999) and the Health Sector Strategic Plan 2000/01 to 2004/05 (HSSP I). Subsequently, the PPPH Working Group has taken up the NGO health sector panel's role. The PPPH Working Group is one of the Technical Working Groups that operate under the Health Policy Advisory Committee (HPAC) for the implementation and monitoring of the national strategic plans. The MoH, with assistance from the Italian Cooperation, established a PPPH Desk to coordinate PPPH activities in 2000. The areas for partnership were identified as: policy development, coordination and planning; resources management including financial resources mobilization and allocation, and human resources for health development and management; service delivery including management and provision of health services and community empowerment and involvement (MoH, 2003). While the PPPH Policy refers to partnerships with the whole private health sector, in practice the MoH's partnership initiatives have focused almost exclusively with the PNFP sub-sector. They are consistently involved in PSD with the MoH and have MOUs.

3.3. Policy Framework for Private Sector Engagement

3.3.1 Economic Development Policies Encouraging PSE and Growth

There are twin policy goals supporting an active private sector role in health: social and economic development. Improving the health of Uganda’s population is intrinsically linked with the country’s overall growth, development and prosperity.

The *National Poverty Eradication Action Plan* (PEAP) 1997-2008 recognized that for development to be sustainable, health and economic growth must be mutually reinforcing. The *National Development Plan 2010-2015* (NDP I) stressed the private sector’s role in spurring economic growth, creating jobs and contributing to social development while the NDP II 2015-2020 envisages modest growth largely driven by public and private investments. The non-public sources of financing will include PPPs, direct private sector investments and CSO contributions. Table 3.1. details key aspects of these policies as they relate to a private sector role in the Uganda economy and in health.

Figure 3.3 National Policy Framework Supporting the Private

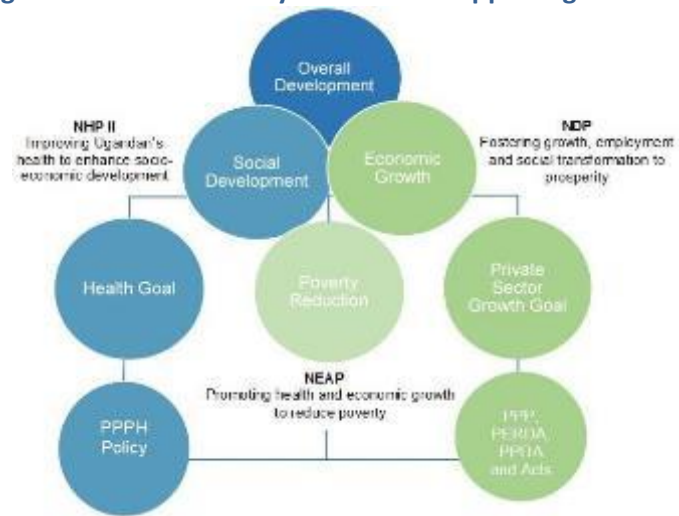


Table 3.1 Private Sector References in Uganda’s Economic Development Policies

Policy	References to the Private Sector
1995 Constitution and Liberalization Policies	<ul style="list-style-type: none"> Encourages the private sector to invest in socio-economic goods and services
National Poverty Eradication Action Plan (PEAP) 1997-2008	<ul style="list-style-type: none"> Overarching planning framework for the country Recognizes that for development to be sustainable, health and economic growth must be mutually reinforcing All government and private sector partners in health should work together towards poverty eradication and economic growth Quality of life and social well-being through increased private participation in social-economic activities Ministries, departments as well as district and local government agencies to promote partnerships and to implement projects and programs, including in the area of social services such as health
National Development Plan 2010-2015 (NDP I) Vision 2040	<ul style="list-style-type: none"> NDP maintains poverty eradication but also focuses on economic transformation and wealth creation Improve socio-economic indicators by raising income and human development indicators through job creations and access to quality social services Private sector still engine of economic growth Recognizes that high quality livelihood for all Ugandans can only be achieved through public and private health interventions Supports private initiatives in health care delivery
National Development plan 2015 – 2020 (NDP II)	<ul style="list-style-type: none"> The macroeconomic strategy envisages modest growth largely driven by public and private investment The non-public sources of financing will include; PPP, direct private sector investments and CSO contributions

The Public-Private Partnership Act	<ul style="list-style-type: none"> • Provides for PPP agreements • Establishes a PPP Committee and Unit • Provides for the management of PPPs
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3.3.2 Health Sector Policies that Set the Stage for Private Sector Engagement

As Table 3.2 shows, several policy documents and plans that acknowledge the private sector’s role and contribution in health and encourage a greater role for them to help achieve public goals such as access, equity, efficiency and sustainability. The centerpiece of all the MoH’s policies and plans is the PPPH Policy.

Uganda is one of the first Sub-Saharan African countries⁸ to pass a PPP Policy translated to the health sector with draft implementation guidelines for PNFPs. The PPPH Policy clearly describes the goal for PPPHs, the rationale for the MoH to partner with non-state actors and maps out the institutional arrangements for implementation (PPPH Policy Brief, 2015). As Figure 3.4 illustrates, the PPPH Policy also details the strategic areas for PPPHs.

Table 3.2: Private Sector References in Uganda’s Health Sector Policies

Policy	References to the Private Sector
National Health Policy I (1999) and II (2010)	<ul style="list-style-type: none"> • Acknowledge role of private health sector in health • Provides legal framework for public sector to engage private sector to deliver goods and services on behalf of MoH • Outlines strategy to build and utilize full potential of PPPs in health • Establishes functional integration between public and private sector in health care delivery, training and research
Health Sector Strategic and Investment Plan (HSSIP) 2010-2015; HSDP 2015/16-2019/20	<ul style="list-style-type: none"> • Recognizes private sector as a critical partner to implement HSSIP and to deliver the Uganda Minimum Health Care Package (UMHCP) • Stresses urgency for the GOU to strengthen partnerships with all stakeholders • Admonishes MoH to establish policy and legal framework conducive for PPPHs • Guides participation of all stakeholders in health development of Uganda
Public-Private Partnerships in Health Policy 2012	<ul style="list-style-type: none"> • Acknowledges private sector contribution in health and admonishes private sector to have a role in achieving UHC in the areas of increasing access, improving equity, strengthening efficiency by maximizing assets and assuring quality of all healthcare providers, and creating mixed health system that complements each other. • Defines private sector as PNFPs, PHPs and TCMPs. • Priority areas for PPPH include: 1) policy development and HSSP monitoring; 2) Coordination and planning; 3) financial resource mobilization; 4) human resource management; 5) capacity building and management; 6) community empowerment; and 7) service delivery. • Establishes institutional arrangements as well as roles and responsibilities at central, district and community levels to implement PPPHs • Recommends formalizing PPPs and suggests certain modalities of PPPs relevant to Uganda context
Health Specific Strategies	<ul style="list-style-type: none"> • Private sector role discussed in HIV/AIDS Policies and Plans • Private sector role discussed in Maternal and Reproductive Health Policies and Plans

Although Uganda has a robust policy framework, as stakeholder interviewees shared, the Achilles heel continues to be weak implementation, resulting in minimal involvement in the private sector particularly PHPs, in policy and planning. There is also limited coordination of public and private sector resources such as services, infrastructure, finances and HRH, and few PPPHs to date.

⁸ Other countries that have some form of PPPH policy, implementation guidelines and/or strategy include Ethiopia, Ghana, Nigeria, Tanzania, South Africa and Zambia. There are many other countries with draft policies waiting for approval such as Kenya, Malawi and Namibia.

Figure 3.4 Strategic Areas for PPPHs



3.4. Factors Enabling / Hindering Private Sector Engagement

Using the framework illustrated in Figure 3.2, this section analyses the range of factors hindering or enabling private sector engagement (PSE) and alignment of private health sector activities to UHC. The section closes with a table summarizing the findings and overall conclusion on how supportive the operational environment is.

3.4.1 Policy Conditions

Overall, the policy environment is conducive for private sector engagement

Through the government stakeholder interviews, the PSA team observed a qualitative shift in government attitudes in working with the private health sector. Ten years ago, most East African countries were struggling with *whether to work* with the private sector, particularly PHPs. Almost all East African countries, including Uganda, have now moved to how to work with the full range of private sector actors in the health sector. The Ugandan government has put into place the policy framework and the institutional arrangement needed to engage the private sector. The PPP Act 2015 confers authority to all government agencies to engage the private sector to deliver goods and services on behalf of the government in all aspects of Ugandan economy. The MoH's PPPH Policy translates the PPP Act to the health sector and articulates in what areas the MoH will work with the private sector. Furthermore, the PPPH Implementation Guidelines describes how the MoH will work with PNFPs. GOU has put into place the necessary institutions, for example the MoFPED PPP Unit and MoH PPPH Node and PPPH Focal Persons at the district level, to engage the private sector. According to stakeholder interviews, the PPPH Node has become the point of entry for many PNFPs and PHPs to engage the MoH.

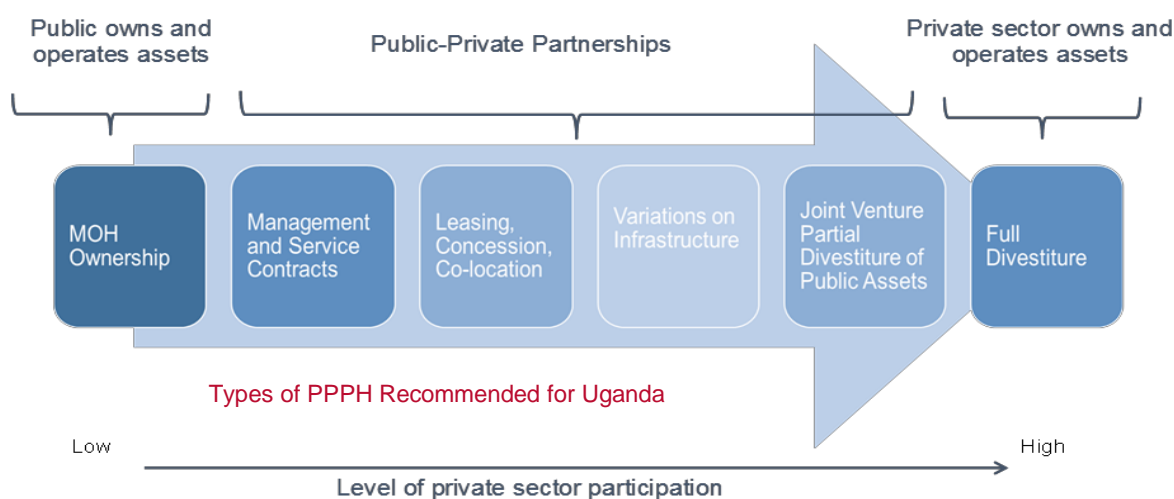
The challenge is to move from paper to action

- The PPPH Policy is a major step forward but requires more awareness. The PPPH Policy is widely known by government sector at the national level, PNFPs and private sector associations, but is barely known outside of Kampala as evidenced by the PSA field visits to the region. District Health Officers and their staff are aware of the policy but in many cases, unwilling to implement it because it conflicts with development partners' regulations. Many PNFPs actively collaborate with Health Management Team in their districts but this collaboration is based on historical relationships and not necessarily guided by the PPPH Policy and implementation guidelines. Finally, most PHPs visited by the PSA Team, with exception of those in Jinja, Mbarara, Mityana and Mbale, do not know of the PPPH Policy nor are they involved in district planning and coordination. These districts have active and trained PPPH Focal Persons that mobilize and involve all private sector stakeholders in their districts.
- There is no common understanding on PPPHs. The PSA site visits revealed that there are more partnerships underway than the MoH headquarters realizes. To date, these partnerships have been informal and ad hoc, primarily between the MoH and PNFPs, and based on historic and/or personal relationships. A contributing factor to MoH resistance to PSE (see below) is the absence of a common understanding of what a PPPH is and what its basic concepts entail. Moreover, many individuals both in the public and private sector do not understand the benefits or the risks in participating in PPPHs. Although the PPPH Policy outlines the priority areas for PPPH interventions, the absence of a common language on PPPHs and a strategy that details priority areas for PPPHs and the types will continue to be a barrier to implementing PPPHs.

“There should be a clear framework for collaboration that is understood by both partners. Dissemination of the policy is key and there should be a clear financing budget line for PPPs. As we stand, there are no proper linkages between the policy and its implementation.”

(Source: Key Informant, MoH)

Figure 3.5 PPPHs Modalities



Source: MoH PPPH Policy, 2012

- Political commitment to PPPHs varies in the public sector. The MoFPED and its PPP Unit is very supportive of the MoH's efforts in private sector engagement. But there are pockets of resistance within the MoH as evidenced by stakeholder interviews during the PSA process. The MoH Department of Planning as well as the regulatory councils are very supportive of working with the private health sector and view this as an important part of their respective mandates.

In addition, the Uganda AIDS Commission has been very supportive of and actively involves the private health sector (see Section 6). However, other health departments are disinclined towards working with PHPs.

- Commitment to work with the private health sector also varies among development partners. As discussed in Section 6, many development partners support MoH engagement and collaboration with PNFs and in some cases (mostly in the area of HIV/AIDS), working with PHPs. Some development partners are reluctant to work with PHPs due to mistrust, limited experience and understanding of PHP contribution, and/or institutional mandate prohibiting them from working with PHPs.
- PPPH Node lacks resources to implement the PPPH Policy. The PPPH Node has a big mandate but limited resources to carry it out. There is no direct budget line to fund the PPPH Node staff and activities. The PPPH Node receives its funds as part of the MoH's Department of Planning budget, but the Node has to compete with the department's other priorities to fund its activities. Some Development Partners like Belgian Technical Cooperation in Uganda (BTC), IFC, Italian Cooperation and USAID have been providing the bulk of technical and financial support to the PPPH Node. The PPPH Node is understaffed; there are only three staff of which a development partner finances one. To understand the potential staffing need, the Department of Health in South Africa has over 15 full-time staff that work exclusively on PPPs. In contrast, in Uganda all three PPPH Node staff work part-time on PSE since they have other tasks besides PPPH to fulfill. Further, the staff lack the skills and competencies needed to implement the PPPH Policy's scope. Although the Focal Person has acquired many of the needed skills over time (e.g. financing, contract law, dialogue, facilities, contract management, conflict resolution), the other staff do not have the experience or the expertise to drive the agenda for private sector engagement and PPPH modalities illustrated in Figure 3.5.

Assuring quality of private services and products is highly fragmented and overlapping

The health professional councils are an important interface between the MoH and the private health sector. The four professional councils (Uganda Medical and Dental Practitioners' Council, Uganda Nurses and Midwives' Council, the Allied Health Professionals' Council and the Pharmacy Council) license all healthcare providers including public ones, and register all private facilities. When interviewed, the councils confirmed that they are primarily responsible for assuring private sector quality of care by enforcing licensing and registration standards, validating continuing medical education requirements, and following up those who fail to maintain their licenses. Through the District Health Management Teams (DHMTs), they also visit and monitor private providers and facilities compliance and quality of care. Other MoH autonomous bodies, like the Central Public Health Laboratories (CPHL), National Medical Stores (NMS) and the National Drug Authority (NDA) play a similar role for the laboratory and pharmaceutical segments in the health sector. The PSA Team found that there are multiple agencies involved in regulating private sector quality with similar functions that overlap. Private sector stakeholders stated that the roles and responsibilities between these different agencies are not clear and there is little coordination between these agencies, with cumbersome and often duplicated procedures creating confusion among their target groups. A private facility, for example, is required to register with multiple councils if they offer clinical, pharmacy and laboratory services.

"Quality is a big concern. The frameworks are in place but because of manpower and insufficient finances, their mandate is not fully operationalized. The regulatory councils are not doing enough. Enforcement is still a challenge."

(Source: Key Informant, MOH)

These duplicated procedures are costly to them in terms of money and time. Stakeholder interviews also revealed that standards for measuring quality are difficult to adhere to, because they are different for each regulator. Moreover, enforcement is weak.

Councils do not have the staff, resources or tools to shut down unscrupulous providers and DHTs do not have the resources to visit and supervise all health care providers including PHPs. As a result, quack service healthcare providers with unscrupulous behavior e.g. drug sellers and labs can slip through the cracks in the system. In light of the resource constraints and limitations of the current QA system, the Self-Regulatory Quality Improvement System (SQIS) is a promising approach to address these gaps (see Box 3.2).

The MoH needs essential tools of government and critical systems

In many middle and high-income countries, public health agencies use a range of *regulatory and financial policy tools* to manage a mixed health delivery system in public interest. MoH officials typically lack the knowledge and tools needed for the shift from managing a public system to a mixed delivery system, and therefore struggle with their new roles and responsibilities (Harding et al, 2015). MoHs have to modify and/or update existing policy tools to accommodate new actors in health and establish new ways of interacting with non-state providers (Tynkynen, Keskimaki et al. 2013) and Uganda needs to do this as soon as possible.

More tools in the toolbox. Most public officials are familiar with and experienced in using a set of tools to guide service provision within the public sector. These tools, referred to as *internal policy tools*, cover strategic planning, annual budgeting, human resource management, quality of care supervision and health information systems, etc. Often MoHs confuse these internal tools with the *external tools* needed to steward and guide non-state actors *external* to the MoH service delivery network. In fact, few officials are familiar with external policy tools (Harding et al, 2015), key among which are:

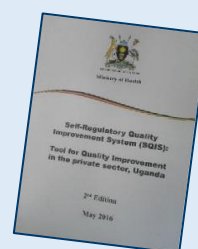
Box 3.2 Promising Approach to Quality Assurance in the Private Sector

The USAID/Private Health Support Program (PHS) is supporting the Health Professional Councils and KCCA to streamline and standardize quality measurements for the private sector. The MoH QA Department, all four councils and private provider associations worked together to develop a simple tool - Self-Regulatory Quality Improvement System (SQIS) - that can be self-administered.

PHPs and PNFPs providers can access the tool through a website (www.sqis.med.ug) managed by the councils. A PNFP or PHP facility can carry out the self-assessment using multiple platforms: the web, mobile phones or computer. The tool generates a score that the individual provider and/or facility can compare over time. The individual and/or facility can also benchmark their scores and progress towards improvement with other facilities.

The councils and KCCA are the “owners” of the SQIS. They will maintain the website, update the tools as clinical standards evolve, analyze the data submitted by PNFPs and PHPs, and share their findings with both MOH and private sector representative organizations.

The councils will work with two groups to roll out the SQIS: with DHOs and their staff to use the SQIS to monitor and track private sector quality in their respective districts; and with private provider associations such as UHF, UPMA, and or networks, such as bureaus, franchise networks etc., to institutionalize use of SQIS among their members and providers. To date, the MoH and its partners have introduced SQIS to over 200 facilities.



- **Data to regulate and monitor private sector activities in the health sector.** The PSA Team’s challenging experience in collecting data illustrated how poor and unreliable the data is on PHPs and to a lesser extent PNFPs – a comparison between MoH’s Human Resource Information System (HRIS), the councils’ registries and PNFP’s service statistics revealed that PNFP data is also unreliable.

Further, all the data on private sector is scattered across different departments and agencies within the public sector - no one group within the MoH has the complete pictures on the size and scope of the private health sector. The different departments and agencies also use different systems to collect data (mostly paper-based). The data problem is further compounded by the fact that few PHPs do not report to the MoH's DHIS 2.

- ***Inclusive policy and planning processes that integrate all stakeholders – including PHPs - perspectives.*** Although there are governance and management structures at the MoH like the HPAC and PPPH-TWG, the private sector is not well represented. The membership of the PPPH TWGs as laid out in the MoH Guidelines for the Governance and Management Structures includes a representative from the PHP sector, but the PHP has not yet organized itself well enough to field a candidate acceptable by all of them. The PPPH TWG meets regularly, but PHPs representation is irregular. The Compact for Implementation of the HSSIP clearly stated the need for involvement of all partners in the health sector in planning, supervision, monitoring and evaluation, However, PHPs were in the past not involved in the annual sector performance review meetings and district level planning. As a result, MoH policies and five-year plans underestimate PHP potential contribution, do not fully harness PHP resources and reflect only one side (PNFP) of all health sector activities.
- ***Unified, Streamlined and up-to-date licensing and registration systems.*** Each professional council has its own registration and licensing process – all still dependent on paper-based systems. The technology is out-of-date, the information is “siloes” by each council and is not readily shared between them or with consumers who are concerned about whether their healthcare providers are legitimately licensed. Private providers and facilities have to register with multiple government agencies depending on size and location of facilities as well as their ownership. The MoH is aware of this gap and is in the process of modernizing the professional licensing and facility registrations processes in addition to quality monitoring (see Box 3.3).
- ***Functional Regulatory Framework.*** The current registration and licensure systems are fragmented between the councils, the MoH departments and the local authorities. The PSA team uncovered several regulatory glitches complicating the regulation of the private sector as; (1) multiple licensing agencies e.g. for facilities with many service areas, one has to get licenses from local councils, regulatory councils, Atomic Agency among others. (2) Duplication e.g. in the pharmaceutical sector the regulatory entities overlap in their functions. (3) Gaps e.g. there are no guidelines for drug pricing and no regulatory body is currently doing QA on lab testing kits. In addition, there are no guidelines for minimum requirements for wholesalers and distributors. These and other challenges in regulatory frameworks as discussed in other sections of this report. More challenging still is the fragmented approach to monitoring quality of both health services and drugs. The councils do not have streamlined and modern inspection tools linked to clinical standards and continuing education hours. Lastly, the MoH and regulatory agencies are, for a variety of reasons, unable to enforce regulations effectively. The councils are in the infancy stage of understanding how to streamline regulations and agencies through a National Health Professionals' Authority, which has been accepted by other East African MoHs which are consequently implementing initiatives to modernize and update their systems (see Box 3.3). In short, the private health sector is inadequately regulated and compliance is mostly voluntary.

Box 3.3 Promising Approach to Modernize Regulatory Systems

The USAID Private Health Support Program (PHS) is supporting a joint initiative with three out of the four health professional councils to update and modernize professional certification and facility licensure using modern technology. The Councils are creating a web-based platform that will enable all healthcare professionals to reapply and pay for their professional certification and for all private businesses to apply for facility licenses. The new system will:

- Develop a single, uniform application and process to be used by participating councils
- Collect consistent and standardized information that will clearly delineate public, PNFP, PHP and dual practices among professionals and facilities
- Centralize all data collection and reporting
- Align and apply MOH facility classification across all sectors, and
- Streamline facility inspection using a web-based tool.

In addition, the councils are developing a single, universal tool common to all councils and regulatory authorities to inspect facilities. They are linking continuous professional development (CPD) hours to clinical standards in the SQIS and developing a system to track and issue CPD hours.

Finally, the councils will also integrate SQIS data (see Box 3.2) with professional certification and facility licensing.



3.4.2 Public-Private Relations

PHPs are largely absent from governance structures and forums that engage stakeholders

At the national level, the Ugandan MoH established several governance structures and forums to foster dialogue and coordination. These structures and forums include the Top Management Committee, the HPAC, the Senior Management Committee, Technical Working Groups (TWGs), the Joint Review Mission and the Health Assembly. They promote multiple stakeholder engagement, including local government authorities, CSOs, PHPs and PNFPs. Given PNFPs' long standing working relationship with the MoH, they participate in all the relevant forums – HPAC, TWGs and Health Assembly – as well as the annual Joint Review Meetings. PHPs, However, PHPs are largely absent at these forums.

HPAC is the logical forum for public-private dialogue on sector-wide issues. However, PHPs and even district health officers (DHOs) are not represented in HPAC. Over time, participation in HPAC has waned - even MoH representatives do not actively participate in all the meetings (HSSIP 2010-2015). Key informants shared many reasons why HPAC is no longer as productive: i) that the HPAC terms of references not widely shared; ii) there are too many TWGs (12 in total) that stretch participants' capacity to stay involved; iii) there is no mechanism for a replacement to stand in for the assigned representative; iv) meetings are called on an ad hoc basis and do not stick to a regular schedule, and v) there are infrequent meetings resulting in low productivity.

Trust is a necessary condition for the public and private health sectors to work together and for PPPs to be successful (Ravishankar et al, 2016). But many of the fundamental conditions needed to build trust and a sustainable working relationship are inadequately addressed in HPAC such as: i) open and regular dialogue between public and PHP groups in a formal mechanism, ii) shared information between the sectors, and iii) inclusion of PHP perspective and concerns in all aspects of health policy and planning at both national and regional levels (Herzberg, 2013).

Old mindsets on PPPs persist in both sectors as noted during stakeholder interviews

On the private sector side, i) PNFPs feel they are treated as an extension of the MOH but not as an autonomous and equal partner; ii) PHPs feel underappreciated, that their contribution is not recognized, and isolated from the rest of the health sector; and, iii) PHPs are frustrated that they cannot access subsidies and exemptions when offering PHC services to the poor. On the public sector side, the MoH i) still believes that all health services should be free; ii) complains about PHPs' quality yet they do not have adequate data to substantiate these claims; iii) do not trust PHPs because they do not report regularly to the MoH; iv) believe that PHPs are only concerned about making a profit and they tend to trust PNFPs more than PHPs.

Despite these old mindsets, the PHPs still believe partnerships with MoH are important, they want to be more involved in policy and planning, and want to find a **QUICK** way forward to build their relationship with the MoH. The PNFPs, on the other hand, want to continue their long-standing and productive working relationship with the MoH but want a **DIFFERENT** form of partnership with the government (e.g. service contracts and social health insurance).

3.4.3 Market Conditions for Healthcare Businesses

The health market is expanding in Uganda and the private sector's contribution to this market is becoming more visible. However, the market conditions are difficult not only for PHPs but also PNFPs as summarized in Table 3.3. The many government benefits PNFPs receive, such as conditional grants, tax exemptions, subsidized inputs are not sufficient to counteract the difficult market conditions that they all face. Key among the multiple barriers both PHPs and PNFPs confront in Uganda are: 1) high cost of inputs and limited government relief for private providers serving poor and underserved groups, 2) commercial banks reluctance to lend money to PHPs and PNFPs despite the rapidly growing private health market, and 3) donor crowding out of PHPs in some health markets e.g. HIV/AIDS and family planning (FP) services.

Also missing in the Ugandan market place are government financing mechanisms, such as national and/or social health insurance, service contracting and demand side subsidies, that are widely accessible to eligible PNFPs and PHPs (See Section 4 Health Financing). Further, there is limited information on public and private sector costs that could enable the MoH and the private sector effectively negotiate the payment terms and conditions for these financing mechanisms. This is a missed opportunity for establishing Diagnostic Related Groups, which can be used to purchase health services. Section 5 further describes the barriers and opportunities in market conditions for private businesses.

3.4.4 Scoring of Enabling Factors

Table 3.3 summarizes the policy environment, working relations between the sectors and market conditions for healthcare business. Overall, the policy environment is conducive to greater private sector role towards UHC. However, governance structures to foster public-private dialogue are weak and working relations between public and private sectors, particularly PHPs, are difficult as are market conditions, which are difficult for not only PHPs but also PNFPs.

Table 3.3 Analysis of Enabling and Inhibiting Factors for Private Sector Engagement

Area	Description	Score
Policy	<ul style="list-style-type: none"> + Important change in government mindset observed. No longer has a question “<i>if we should</i>” but “<i>how can we</i>” work with the private sector, including PHPs. + Policy framework in place as well as a few of the necessary institutions. + Political will in certain pocket of the Ugandan government and MOH departments. + PPPH Node in place and serves as an entry point for private sector engagement with MOH. 	Satisfactory
	<ul style="list-style-type: none"> + Political commitment varies between MOH departments delivering health services. ACP is supportive but all other departments are reluctant and in some cases, antagonistic. + Development partners’ commitment varies as well. Most support working with mostly PNFs. And a few will support PHPs, particularly in HIV/AIDS. But there are some who will not work with PHPs. 	
Relationship	<ul style="list-style-type: none"> + HPAC is logical forum for public-private dialogue with strategic modifications to its membership and scope. + PHPs still believe partnerships are important, want to be more involved in policy and planning, and are looking for quick and feasible strategies to build its relationship with the MOH. 	Weak difficult
	<ul style="list-style-type: none"> – Suspicion and misunderstanding of profit motive in health. Lack of trust persists between sectors. 	
	<ul style="list-style-type: none"> – MOH is not aware nor acknowledges private sector contribution in health due to limited information on non-state actors’ health activities and partnerships. 	
	<ul style="list-style-type: none"> – Long standing philosophy that all health services should be free. Believe quality is poor among PHPs without data to back up claim. 	
	<ul style="list-style-type: none"> – MOH does not actively and systematically engage and/or include private health sector in policy and planning. – Private sector resists sharing information with MOH. 	
Market Condition (see Section 5)	<ul style="list-style-type: none"> + Health market growing at accelerated rate. + Positive experience in commercial lending to build on in Uganda health sector. + Both PNF and PHPs want to strengthen business and financial skills to better manage costs, improve operations and become financially sustainable. + Many PHPs deliver key services to the poor. They could expand their services with access to government and/or donor benefits. 	Weak difficult
	<ul style="list-style-type: none"> – MOH does not have accurate info on size and scope of private sector. 	
	<ul style="list-style-type: none"> – Although health sector is growing rapidly, there is limited access to finance for health businesses including PNFs. 	
	<ul style="list-style-type: none"> – Both PHPs and PNFs experience high costs of inputs (e.g. land, power, water, and infrastructure) PHPs have double burden of income and other taxes (e.g. V.A.T. and import tax). 	
	<ul style="list-style-type: none"> – Both PNFs and PHPs need access to capital so they can improve their facilities, purchase needed equipment and supplies, which ultimately produces benefits for the health sector. 	
	<ul style="list-style-type: none"> – With high cost of inputs and lack of access to credit, PNFs face financial uncertainty under current government financing mechanisms. 	
	<ul style="list-style-type: none"> – Donor funds crowd out PHPs in certain markets (e.g. FP, TB and HIV/AIDS). 	

Very Strong Strong Satisfactory Weak/Difficult Very Weak/Very Difficult

3.5. Recommendations

The PPPH Policy is at a critical juncture – the slow operationalization of the policy will jeopardize private health sector support and buy-in towards collaboration and partnerships. The PPPH Policy has generated a lot of excitement and high expectations among PNFs and PHPs and other partners. The following are a series of recommendations that will signal MoH’s commitment towards a conducive policy environment.

1. **Change the MoH mindset on working with private health sector.** There is growing and rich experience in both OECD and developing countries on the benefits and mechanics of working with the private sector to achieve UHC. The PSA team recommends assisting the PPPH Node, in its capacity as the nexus between public and private sectors, to build their capacity to make the case for private sector engagement. This will entail: 1) identifying core themes on PSE that will help change MoH mindset on working with the private health sector, 2) gathering and presenting the evidence on private sector contribution in Uganda building on the PSA, 3) gathering and presenting international experience in PSE, 4) organizing domestic and international study tours to observe successful PPPHs, and 5) facilitating greater interaction and dialogue between MoH leadership and private sector, particularly PHPs and their representatives to build trust.

2. **Demonstrate MoH's goodwill and commitment to partner with the private health sector, particularly PHPs.** There is a window of opportunity NOW to break through old mindsets. Despite all the challenges they confront, the private sector is looking to the MoH to immediately demonstrate leadership and commitment. First and foremost, the PSA Team recommends the MoH immediately broker one to two PPPHs (see below for more details) to assure the private sector that the MoH is serious about implementing the PPPH Policy. Second, MoH should establish a public-private dialogue (PPD) mechanism by:
 - 1) updating HPAC's mandate to include being *the* forum for PPD; 2) reviewing HPAC's terms of reference to increase PHP representation from one to two members, 3) encouraging the PHP sector to determine who will represent them, 4) establishing the ground rules for greater PPD within the HPAC framework; 5) improving the attendance of all members including PHP representatives at the monthly HPAC meetings; and 6) making a concerted effort to interact and engage the private health sector through many of the policy and planning initiatives listed below. Donors, as demonstrated by PPD efforts in Kenya, Tanzania and Malawi, can play a critical role by offering financial resources to jump start and maintain the PPD process, provide technical assistance to establish ground rules for PPD, help build participants' capacity to work together, and grant seed money to support joint projects to demonstrate the ability to work together.

3. **Invest in the PPPH Node's capacity to fulfill its mandate.** As noted before, the PPPH Node has a big mandate but is woefully under-funded and supported by government. The Program and BTC are currently supporting the PPPH Node to build its capacity to implement the PPPH Policy. Building on the current efforts, the PSA team recommends:
 - ***Institutionalizing the PPPH Node.*** There are elements of the PPPH Node already in place, such as draft terms of references, partial staffing plan and a skills gap analysis. The PSA Team recommends building on the existing documentation to develop a strategic plan to operationalize and institutionalize the PPPH Node's scope. Donors can once again play a critical role in supporting the number and type of staff needed to fulfill its mandate. The Node requires to be elevated to division level within the MoH, and staffed with people having the skills and expertise for PPPs. Once again, the term of reference for the PPPH Node will have to map onto the current decentralization initiatives and clearly outline what roles and responsibilities will be performed at the national and district level by the PPPH focal persons. There is also an opportunity to outsource some of the tasks under the PPPH Node.
 - ***Designing operating systems and procedures.*** There are many examples of PPP unit's operating system and manuals from South Asian (e.g. India and Bangladesh) and African countries (e.g. South Africa, Tanzania) that can serve as a template for the PPPH Node in Uganda. Tasks include a) designing and building operating systems, b) developing an operational manual,

c) training PPP Node staff in the new operating systems, and d) educating MoH on the PPPH Node's functions, roles and responsibilities.

- **Generating data needed to regulate and monitor the private health sector.** The PSA underscores the lack of data on the private health sector, making it difficult for the MoH to regulate but also make strategic decisions on how to engage and partner with them. One of the first functions of the PPPH Node is to conduct further research on the private health sector following the PSA's recommendations. Donors could support the PPPH Node to carry out a series of analyses to address this information gap that may include: a) updating and reconciling MoH statistics on all HRH and facilities, b) developing an inventory of existing PPPHs to serve as the registry for PPPHs, c) conducting a health equipment inventory in both public and private facilities to identify opportunities to rationalize expensive equipment (e.g. ultra-sounds, CD4 labs, X-ray, MRIs and oxygen), d) expanding the KCCA provider census to cover the entire country, and e) conducting targeted analysis of quality among key private providers who deliver priority health services to identify potential partners for PPPHs.
- **Communicating and sharing information.** One of a PPPH Node's most important functions is to ensure constant and transparent communication and information exchanges between the public and private sectors. In some instances, a PPPH Node is the secretariat for the PPD platform. The PSA team recommends: 1) building a website to avail information on the private sector and PPPH opportunities as well as sharing changes in MoH policies and regulations; 2) building capacity to produce policy briefs on key issues relevant to private sector role in health, 3) providing support to help the PPPH Node convene forums for private sector associations and leaders to participate in all the policy and regulation reforms, and to conduct "trade fairs" in which private sectors can showcase their operations.
- **Building knowledge and capacity in PSE.** Experience in other countries has identified five critical skills areas needed for PSE: costing, contracting, performance based financing, conflict resolution and negotiation. PPPH Node staff will need to learn how to identify, design and monitor contracts and PPPHs. This will require building knowledge on PPPs. There are three possible strategies for building this knowledge base: 1) conduct study tours to countries with successful PPPHs, 2) carry out an inventory of current PPPHs in health and document them, and 3) as Uganda experiments with different types of PPPHs, evaluate them to develop lessons learned and best practices going forward with future PPPHs. Once again, this knowledge and information should be widely shared within the MoH, within the private health sector and among other stakeholders.
- **Brokering a few partnerships in health.** The proof of the MoH's commitment to the private sector is to design a few, simple, low-risk yet highly visible partnerships. The PSA, in Section 6, identifies a few potential areas for partnerships, such as: contracting private pharmacies to deliver a basket of essential medicine; offering counseling on common illnesses; contracting PROFAM providers to decongest maternity wards in KCCA and other public hospitals; contracting private providers to down-refer AIDS patients on ARVs; co-locating private labs in public or PNFP hospitals, and guaranteeing loans for JMS to build regional warehouses that can be leased by the MoH. The MoH will initially require specialists to help them prioritize among the many options, conduct due diligence and financial analysis of bidder's proposals, negotiate and finalize the terms of the contracts

4. **Conduct a systematic review of the MoH’s existing policies, guidelines and regulations.** The PSA identifies several policy and regulatory gaps that if addressed, will resolve many of the quality and adverse behaviors found in the private health sector. The MoH can, with technical assistance and financial resources, a) compile all policies, laws and regulations from the multiple government agencies related to health in Uganda, b) review the policies, laws and regulations to identify gaps, inconsistencies and duplications, c) benchmark the policies, laws and regulations with international standards to ensure best practices are integrated into the current review, and d) present an updated policy and regulatory framework for the health sector that reflects a mixed health delivery system with recommendations on specific changes. Throughout the process, the private sector should work with the MoH to help collect all the necessary documents, participate in the review and analysis to “ground truth” the findings and recommendations according to a private sector perspective, and to help the MoH present the framework and recommendations to MoH leadership. After the framework has been approved, the MoH, with technical assistance and resources, can carry out the recommendations and begin the consultative process of drafting the changes, consulting with the stakeholders affected by the changes, finalizing the changes based on the consultation feedback and disseminating the new regulations widely to ensure all private providers receive and understand them. Part and parcel of this initiative should be the training of both public and private stakeholders and monitoring the implementation of the new policies and regulations.

5. **Build the “policy toolbox” to govern non-state actors external to the MoH.** The Uganda MoH is using internal policy tools to manage external actors and therefore, misses many tools and systems needed to manage the private health sector. The PSA highlights these critical tools as gaps:

1) data needed to analyze sector wide activities, 2) streamlined QA system with private sector participation implemented fairly across the sectors, 3) user friendly licensing and registration processes, and 3) investments in self-regulatory action by professional associations and other intermediaries to monitor and supervise prices and quality in the private sector. The PSA team recommends building on MoH’s momentum and efforts in many of these areas. Specifically,

- **Identify, collect and consolidate data on all private sector activities.** The tasks required include: 1) convening all MoH agencies and the private health sector to agree on the bare minimum of indicators needed for the MoH to understand private sector activities; 2) establish a simple reporting mechanism (preferably web-based) for private sector actors and identify incentives that will encourage or penalize private sector for not reporting; 3) consolidate data reporting and collection into a central location (preferably web-based) that is accessible by all relevant government agencies; and 4) invest in building MoH capacity to analyze, report and use data for performing their regulatory tasks.
- **Streamline QA system by institutionalizing SQIS in both government and private sector entities.** Build on and expand on the MoH SQIS initiative by ensuring continued resources are allocated to the councils so that they operate and maintain the web-based platform housing SQIS. Provide technical assistance to build their skills to collect, analyze, report and use the SQIS data to monitor private sector quality. The next step within the public sector will entail institutionalizing district-level capacity to use the SQIS system to monitor and improve private sector quality in their respective districts. The MoH can use SQIS as a tool to assess eligibility to become a voucher, service contract and/or social health insurance provider. Similarly, it will be important to invest in and institutionalize SQIS in many private sector associations and provider networks as a tool to monitor and improve quality among their members.

- **Modernize registration and licensing systems. Build on and expand the councils’ efforts to modernize their operations and systems.** The Program is scheduled to complete the design and start-up of the modern, web-based system. However, more investment is needed to institutionalize its use by both the councils and public. Part and parcel of this initiative should be training not only MoH staff but also private and industry associations to ensure all stakeholders have the knowledge of and are able to use the new system and tools.
- **Assist the Regulatory Bodies (professional councils, National Drug Authority) to co-regulate non-state actors through third party organizations.** Increasingly, middle and high-income country regulatory agencies are working with third party organizations, such as semi-autonomous agencies, professional associations or other intermediaries, to carry out regulatory functions normally performed by the MoH (Harding et al, 2015). Examples include: working with professional associations to ensure professional licensing and facility registration; tapping into industry groups and trade associations for information and implementation support to ensure compliance with pricing guidelines and mark-up regulations; working with third party players in negotiating and managing contractual relations with hospitals and other types of service providers such as healthcare provider networks, pharmacies, and labs. These experiences demonstrate the efficiency and efficacy of co-regulation. The PSA team recommends exploring opportunities, such as rolling-out SQIS, modernizing professional and facility licensing and services contracting, to experiment and grow the regulatory bodies’ experience in co-regulations.

6. Improve private sector’s ability to dialogue with, participate in policy initiatives and partner with the public sector. A recent study on why PPPs fail indicates that it is equally important to build private sector capacity to engage with the public sector (Ravishankar et al, 2015). Unfortunately, most donors only focus their financial support and technical assistance in building the government’s capacity in PSE.

The PSA Team recommends building private associations and industry groups’ capacity to represent private sector perspective in policy and planning, unifying their voice to advocate for key policy reforms such as national health insurance, and helping to organize the private sector by serving as a third party entity for many of the policy reforms. Building private professional associations and industry groups entails providing technical assistance to: 1) strengthen their organizational capacity including the identification of a HPAC representative, who can best represent their diversity; 2) become more financially sustainable; 3) enable the associations’ boards to assume their full governance responsibilities; 4) build staff’s competency to carry out membership services. In addition, grants will help these different associations hire staff, carry out activities to earn credibility with members, and represent their constituents in policy and planning initiatives.

4. THE ROLE OF HEATH FINANCING IN CREATING A SUSTAINABLE PRIVATE HEALTH SECTOR

The WHO states the government role in health financing is to make sure that sufficient funds are available to finance health care and to create appropriate financial incentives to healthcare providers to ensure all individuals have access to adequate healthcare (WHO, 2000). Good stewardship of health financing entails creating a health financing system that raises and manages funds in a way that ensures all people have access to affordable, quality health services and are protected from financial catastrophe or impoverishment. Moreover, health financing should incentivize all providers – public and private alike – to deliver care more efficiently and effectively (WHO, 2000).

This section is divided into two parts. First, the section provides an overview of health financing trends based on National Health Account (NHA) analysis, underscoring the sector’s reliance on donor and out-of-pocket (OOP) funds to finance health in Uganda. Second, the later section focuses on the role of public and donor financing for health and its impact on enabling, or in some cases hindering, a sustainable and vibrant private health sector that can contribute towards achieving UHC.

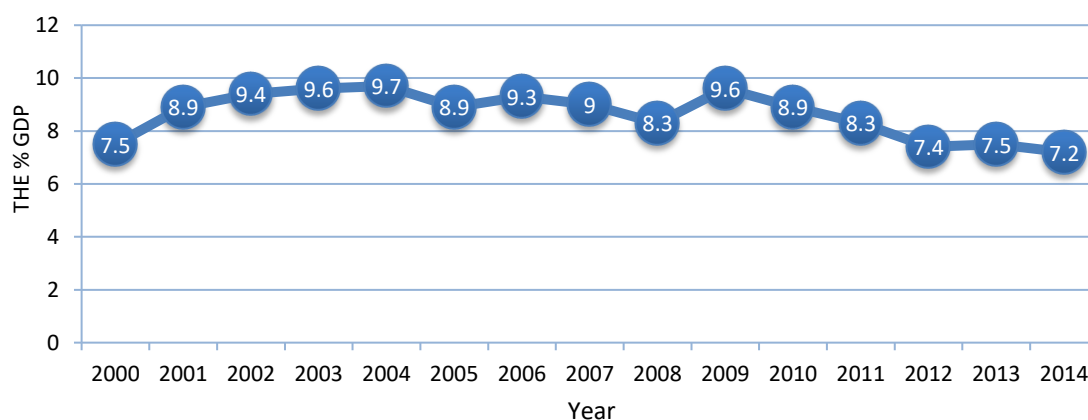
4.1. Introduction to Health Financing in Uganda

4.1.1 Historical Trends

According to the NHA 2004, by the mid-1980s, the health sector was in near collapse with run-down and ill-equipped public health facilities and demoralized personnel (MoH and WHO, 2004). The situation worsened with the re-emergence of diseases that had earlier been controlled or eradicated, such as sleeping sickness, TB and measles. During this period, Ugandans mainly sought healthcare services from PNFP and PHP providers, and donors channeled their support to NGOs due to the lack of confidence in the public sector. From 1986 onward, the Ugandan government introduced many health reforms including new health financing mechanisms. As a result, bilateral and multi-lateral donor organizations increased their support to the Ugandan government, especially to the health sector.

Over the last twenty years, government spending on health has been increasing, both in nominal and real terms. According to the WDI, 2016, total health expenditure (THE) was 7.2% of gross domestic product (GDP) in 2014 (see Figure 4.1).

Figure 4.1 Total Health Expenditure as % of GDP 2000-2014



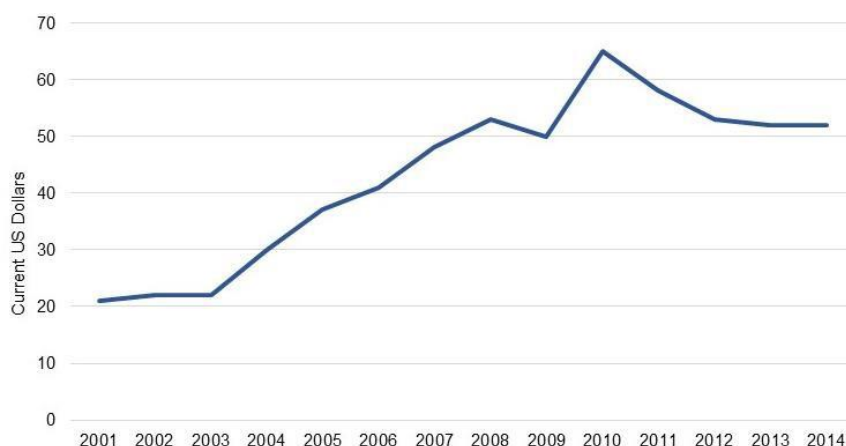
Source:

AHSPR 2013/14 and World Development Indicators (WDI) Database for 2013, 2014

Government allocation to health has fluctuated between 7.2%-9.0% of total government spending the last 10 years (AHSPR, 2014/15). This is substantially lower than the Abuja target of 15% that African Union countries committed to for the improvement of their health sectors.

Per capita total health expenditures in Uganda increased from US \$21 in 2000/01 to US \$52 in 2012/13 (See Figure 4.2). This increase, however, is still low by WHO standards. WHO estimates that it will take sixty dollars (US \$60) to deliver essential health services in a developing country. A recent analysis of SSA countries also projects that Uganda will not meet the sixty-dollar threshold to achieve UHC by 2020⁹ in light of the declining government contribution to the health sector in the last four years.

Figure 4.2 Per Capita Total Health Expenditures in Current US Dollars, 2016



Source: WDI Database, 2016

4.1.2 Health Financing Indicators – Regional Comparison

Uganda compares favorably with other countries in Sub Sahara Africa (SSA) on only a few health finance indicators (see Table 4.1). Uganda’s THE as a percentage of GDP (7.2%) is higher than SSA’s (5.6%). Yet when translated to the amount spent per capita, Uganda is US\$52 compared to SSA’s US\$99 - 47 percentage points less.

Table 4.1 Selected Health Financing Indicators for Uganda and SSA

Selected Indicator	Uganda	SSA	Year	Source
Total health expenditure on health (THE) as % of GDP	7.2	5.5	2014	WDI, 2016
Per capita expenditure on health in current US \$	52	99	2014	WDI, 2016
Government expenditure on health as % of THE	25	43	2014	WDI, 2016
Donor expenditure on health as % of THE	46.3*	10.3	2013	NHA 2011-12/ WDI, 2016
Out-of-pocket expenditure on health as % of THE	41	35	2014	WDI, 2016
Out-of-pocket expenditure on health as % total private health expenditure	55/96*	60	2014	WDI, 2016/ NHA 2011/12

Source: World Development Indicators (WDI) Database and *Uganda NHA 2010/11 and 2011/12;

Table 4.1 also compares the sources of health financing in Uganda with those of SSA. In the case of Uganda, government funding as a percentage of THE is much lower than in SSA: 25% compared to 43%, respectively (WDI, 2016) and OOP is higher in Uganda (41%) in comparison with SSA (35%). Uganda continues to depend on development partners to finance a significant proportion (46.3%) of its health sector.

⁹ Avila Carlos et al. 2013. Universal Coverage of Essential Health Services in Sub-Saharan Africa: Projections of Domestic Resources.

This data supports the stakeholders' view that the health sector is underfunded, particularly in terms of government contribution, and over-reliant on donor funds.

4.1.3 Overview of Current Health Sector Finances in Uganda

Table 4.2 provides data on THE in the last twelve years of NHA reports. There has been a dramatic rise in THE, increasing six times from 745 billion UGX in 2000/01 to 4,751 billion UGX in 2011/12. The rapid increase is due primarily to donor funds – in particular the rapid influx of PEPFAR funds from 2006/07. With its low government allocations and substantial dependence on donor funds, Uganda faces a major challenge in sustaining not only the introduction of new drugs such as antiretroviral drugs and pentavalent vaccines, but also expanding health infrastructure to meet the growing demand for health care (Okwero et al, 2010).

Table 4.2 Health Expenditure by Financing Source in Billion UGX

Financing Source	2000/01		2006/2007		2009/2010		2011/2012	
	Value	% of Total	Value	% of Total	Value	% of Total	Value	% of Total
Households-OOP	302	40%	826	51%	1,372	42%	1,776	37%
Development partners	305	41%	548	34%	1,328	41%	2,198	46%
Government	136	18%	235	15%	472	15%	725	15%
Other private	2	0.3%	-	-	63	2%	52	1%
Total	745	100%	1,609	100%	3,235	100%	4,751	100%

Source: NHA, 2008/2009 and 2011/12

Domestic sources of health finances include public (government resources) and private sources (households and employers). Government's contribution includes central government funds (from taxes), local government funds and donor funds channeled through national budget support. Household sources include individual OOP and private health insurance but the latter (insurance) is negligible in Uganda (NHA, 2011/12). External sources are comprised mainly of bi-lateral and multi-lateral donor funds.

Figure 4.2 demonstrates development partners are the largest source of funds for health in Uganda. Their contribution has increased from 40% in 2000 to 46% of THE in 2012. Government contribution on the other hand has declined over the same years from 18% to 15% of THE. According to the NHA 2011/12, the majority of overall health funds were spent on outpatient curative services (45%) followed by inpatient curatives services (27%) and preventive services (16%). Despite the government's policy emphasizing preventive care, it still remains a low priority as evidenced by the low funding level.

Individual households (OOP) are a major source of health financing in Uganda contributing 37% of THE (NHA 2011/12). Although OOP has declined from 42% in 2000 to its current level, reliance on household expenditures is widely recognized as an inequitable way to finance health, often resulting in impoverishment.

4.2. Total Health Expenditures by Functions

To achieve financial protection and equitable access to health services, health revenues must be collected fairly, should be effectively pooled and managed, and should be used to purchase services strategically and efficiently. Figure 4.3 applies Kutzin's framework to analyze health financing functions to the Uganda setting and shows the relative contribution of each sector by revenue sources, pooling and provision of health services (Kutzin, 2001). This section uses this framework to discuss the relative public-private contribution for: revenues (funding sources), pooling (insurance) and purchasing (contracting). Section 6 discusses the public-private mix of health services and goods.

Table 4.3 Health Financing Functional Chart for Uganda, 2014

Revenue Collection	Public	Development Partners	OOP	Voluntary Health Insurance
Pooling	Ministry of Health	Private Not for Profit	OOP	
Purchasing	Ministry of Health	Private Not for Profit	OOP	
Provision	Public	Private Not for Profit	Private	

Source: Health Financing Strategy 2016

4.3. Revenue Collection for Health Financing

In Uganda, there are three main sources of funds to finance health: i) public funds, ii) development partners and iii) private funds. Each are discussed in turn in the following sub-sections.

4.3.1 Public Funds

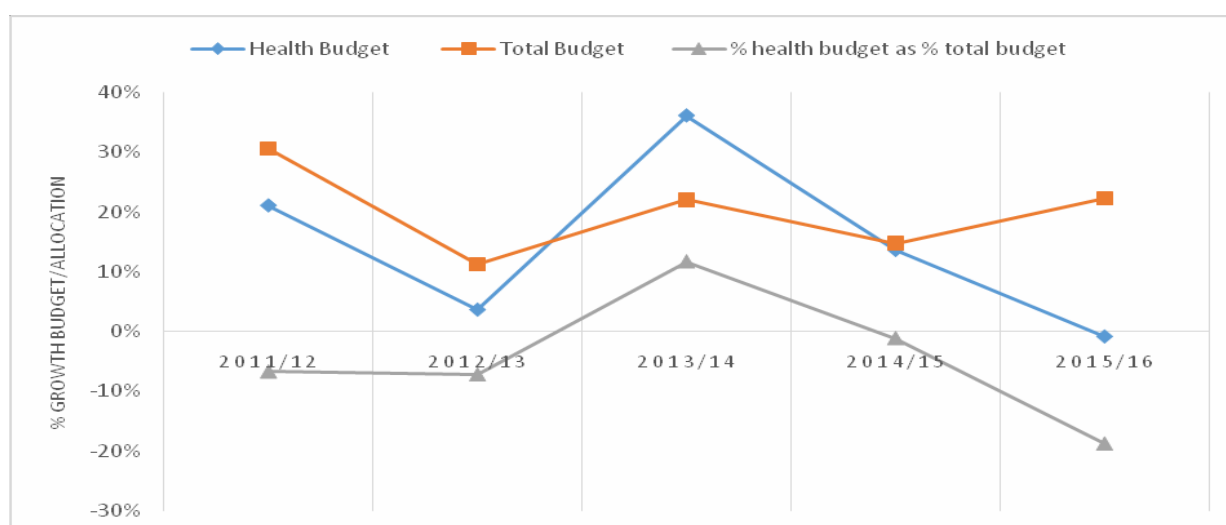
Although Uganda’s government budget has been increasing over the years, allocations to the health sector have not matched this growth. As Table 4.3 indicates, the health budget increased by 93% over 5 years (FY 2010/11-2015/16) from UGX 660 billion (FY 2010/11) to UGX 1,271 billion (2015/16), while the total government budget increased by 148% from UGX 7,377 billion (FY 2010/11) to UGX 18,311 billion in FY 2015/16 (MoFPED, 2016). This indicates that the health sector budget as a percentage of total government budgets has been declining in the last five years (Figure 4.5). Increased external resources have been the main drivers for the growth in the health budget (see Section 4.4.2 for more details).

Table 4.4 Total GOU Budget and Health Sector Budget (FY 2010/11-2015/16)

Year	Billions (UGX)				Health as % of total budget
	Health Budget	Growth	Total Government Budget	Growth	
2010/11	660		7,377		8.9
2011/12	799	21%	9,630	31%	8.3
2012/13	829	4%	10,711	11%	7.7
2013/14	1,128	36%	13,065	22%	8.6
2014/15	1,281	14%	14,986	15%	8.5
2015/16	1,271	-1%	18,311	22%	6.9

Source: MoFPED;

Figure 4.5: Percentage Growth in GOU Total and Health Budget, Uganda



Background to the Budget 2015/16

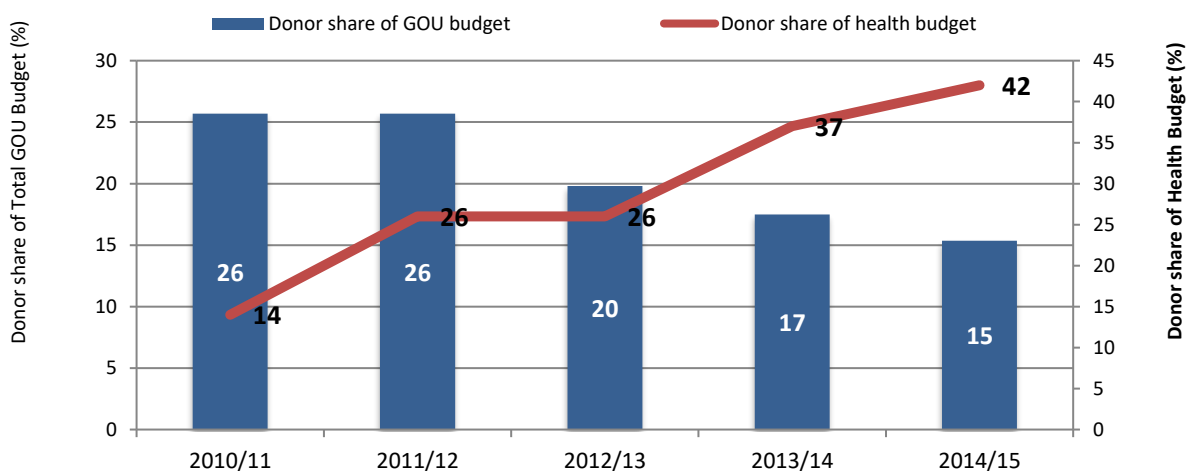
According to the Uganda Health Systems Assessment (2011) to ensure at least the same level of budgetary financing for health, the government will have to increase its portion of THE from 15% to 20% in subsequent years to keep pace with population growth, inflation and rising foreign exchange rates (MoH, 2011).

According to current fiscal projections, Uganda’s health budget will continue to grow at a modest rate (HFS, 2016). In the medium term (by 2021), the country expects revenue from oil industry, which it hopes to utilize in high return public investments. However, in the initial stage, this sector will require heavy investment and allocation of government resources to the mining industry has contributed to further tightening of the fiscal situation. The challenge going forward will be convincing the government of Uganda (GOU) to shift its spending priorities away from the energy and infrastructure sectors to social sectors such as health (HFS, 2014). In the meanwhile, the health sector has potential to increase the effectiveness of its current funds by promoting prudent fiscal management and governance to reduce the inefficiencies and wastage that consume upwards of 13% of THE (Okwero, 2010).

4.3.2 Development Partners

According to MoFPED, Overseas Development Assistance (ODA) as a proportion of the total government budget has been decreasing over the last five years, but in health, donor assistance has increased dramatically. While ODA contribution to the total government budget declined from 26% in FY 2010/11 to 15% in FY 2014/15 (MoFPED, 2015) the portion of donor resources contributing to the total health budget increased from fourteen 14% to 42% in the same period (HFS, 2016). The dramatic rise in donor funding is attributed to increased contribution of Global Health Initiatives specifically, PEPFAR, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) and the GAVI. During this period donor funds grew seven-fold from 305 billion UGX to 2,202 billion UGX. The most recent (2013) National Health Accounts estimates show that external resources were the dominant source of health expenditure contributing 46% of total health expenditure in FY 2011/12.

Figure 4.6 Percentage Contribution of ODA to Total GOU budget and Health Budget

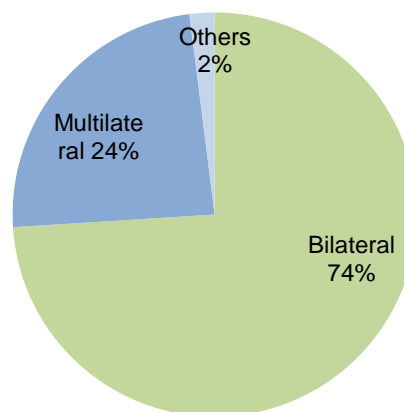


Source: National Budget Framework Paper 2010/11-2014/15 (MTEF); NHA

Among the development partners, bilateral donors contributed three-quarters (74%) of all development partner funds in FY 2011/12, excluding not-for-profit Institutions servicing households (Figure 4.7).

Table 4.5 provides a detailed description of development partners' projects, their area of support, and where their activities are located, while Table 4.6 shows the amount of funds contributed by the top donors. The USG – through USAID, PEPFAR, PMI, Centers for Disease Control (CDC) and other agencies – was by far the largest donor contributing more than two-thirds (66.9%) of all development assistance in the health sector. Other donors' contribution - including bilateral, multi-lateral or private – were less than 10% each and most were less than 5%.

Figure 4.7 Health Funds by Type of Donor



Source: NHA 2011/12.

Table 4.5 Selected Development Partners' Projects by Areas of Focus, 2005-2015

Area of Support	Project	Project Description	Geographic Scope
Child health	GAVI	<ul style="list-style-type: none"> • Donate vaccines and equipment, conduct campaigns and immunize 91% of all children 	All
HIV/AIDS	MILDMAY	<ul style="list-style-type: none"> • Increase demand for and deliver quality HIV and TB prevention, care, and treatment services 	Central, West Nile
HIV/AIDS	USAID/PHS Program	<ul style="list-style-type: none"> • Increase access, availability and quality of services in the private sector (PFP and PNFP) 	All
HIV/AIDS	USAID/NUMAT	<ul style="list-style-type: none"> • Strengthen district management of decentralized health system • Improve the quality of HIV and TB services provided by public health facilities • Strengthen the continuum of care of services between health facilities and their served communities • Increase demand for HIV and TB prevention, care, and treatment services. 	Northern
HIV/AIDS	USAID/STAR-E		Eastern
HIV/AIDS	USAID/STAR-EC		East Central
HIV/AIDS	USAID/STAR-SW		SW
HIV/AIDS	USAID/SUSTAIN	<ul style="list-style-type: none"> • Support the delivery of HIV and AIDS care and treatment services • Enhance quality of care • Support increased stewardship by the MoH and various hospitals to sustain service delivery. 	Central, SW, West Nile, Western
HIV/AIDS	Walter Reed	<ul style="list-style-type: none"> • Vaccine development • Build vaccine testing capability in Uganda • Conduct epidemiological and basic research and provision of HIV Treatment, care and support • Support surveillance of emerging infections 	Central
HSS	SDS	<ul style="list-style-type: none"> • Strengthen systems and public service delivery mechanisms in 100 districts, empower local governments to better meet citizen's needs • Improve effectiveness of decentralization in delivering social services 	Central, EC, Eastern, SW, Western
Infrastructure	AfDB	<ul style="list-style-type: none"> • Upgrade Mulago Hospital • Rehabilitate mental hospitals • Purchase ambulances to strengthen referrals in KCCA 	
Infrastructure	Islamic Devpt Bank	<ul style="list-style-type: none"> • Construct new maternity hospital 	N/A
Infrastructure	World Bank - UHSSP	<ul style="list-style-type: none"> • Upgrade Moroto and Mityana Hospitals • Rehabilitate general hospitals, maternity wards and HCs • Purchase medical equipment and ambulances 	All
Infrastructure	JICA West	<ul style="list-style-type: none"> • Rehabilitation for Regional Referral Hospitals (RRHs) • Purchase of equipment for RRH 	Kabale & Hoima RRH
Infrastructure	Italian Support	<ul style="list-style-type: none"> • Construct staff housing 	Karamoja
Malaria	GFTAM	<ul style="list-style-type: none"> • Scale of rapid diagnostic tests 	All
Malaria	IRS-2	<ul style="list-style-type: none"> • Carry out IRS in all communities 	North
Malaria	PMI GFTAM, DFID World Vision	<ul style="list-style-type: none"> • Train health workers in effective malaria case management • Prevent malaria through universal coverage of LLNs • Make ACTs accessible and affordable 	Central, Eastern, Western
Malaria	Stop Malaria		All
Medicines	SURE	<ul style="list-style-type: none"> • Support on-the-job training on medicine management activities in MoH facilities 	All
RH	European Union	<ul style="list-style-type: none"> • Support CBOs to monitor MoH budget spending • Supports MSI RH programs 	All

Area of Support	Project	Project Description	Geographic Scope
RH	World Bank UHSSP	<ul style="list-style-type: none"> Strengthen MoH capacity to develop and manage HRH Improve MoH management of health services Procure and distribute equipment and EmOC drugs, FP commodities and equipment to health centers Increase demand for FP through vouchers Carry out community awareness campaigns 	All
RH	STRIDES-USAID	<ul style="list-style-type: none"> Increase contraceptive use among WRH Strengthen public and private provider FH services Train RRHs to provide routine fistula services 	Central, EC, Eastern, Western
RH	GAVI, Merck	<ul style="list-style-type: none"> Introduce and scale-up HPV vaccine 	
RH	UNFPA	<ul style="list-style-type: none"> Procure ambulances and create systems to manage them Advocacy to build political support for FP/RH services 	Central, Eastern, Western
RH	USAID Voucher	<ul style="list-style-type: none"> Increase access to skilled delivery among poor women living in rural and disadvantaged areas 	14 districts in SW and 12 in Central Eastern
TB	Stop TB	<ul style="list-style-type: none"> Increase DOT of TB coverage Scale-up multi-drug resistant TB treatment to RRHS 	Mbarara, Mbale, Gulu, Fort Portal.

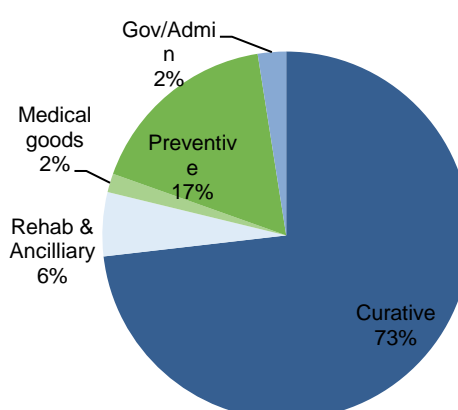
Table 4.6 Top Donors' Health Funding, 2011/12

Donor	Amount (UGX million)	Contribution %
United States Government	1,469,928	66.9%
GAVI	187,191	8.5%
UNFPA	56,462	2.6%
United Kingdom	55,360	2.5%
Denmark	42,100	1.9%
Ireland	40,903	1.9%
UNICEF	19,493	0.9%
Belgium	17,232	0.8%
WHO	15,136	0.7%
UNDP	12,426	0.6%

Source: NHA, 2011/12 Table 6-5

The majority of donor funds were spent on curative care (73%), particularly in the area of HIV/AIDS and TB. Only 17% was spent on prevention (see Figure 4.8). Further analysis of the funds spent on prevention reveals that they were spent on, in order of priority, disease control programs, information, education and communication and immunization.

Figure 4.8 Donor Expenditure by Function



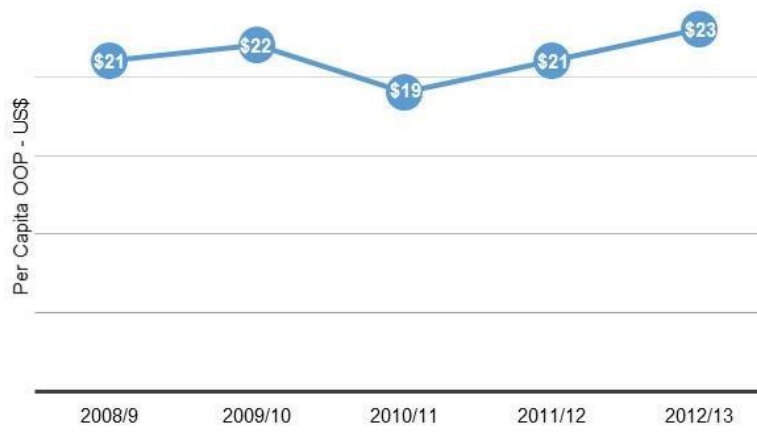
Source: NHA 2011/12. Table 8-4

4.3.3 Private OOP Funds

The proportion of households that incur catastrophic health expenditure in a country is widely used as an indicator of the extent to which the health system protects households needing healthcare against financial hardship. The HSDP 2015/16-2019/20 recognizes that a major share of the financing for the health sector comes from private sources. The 2011/12 NHA determined that 38% of THE is from private funds and most of this (97.3%) comes from individual OOP expenditures. The balance (about 3%) comes from private health insurance, which remains extremely low in Uganda. This is almost double the WHO recommended level of OOP for minimizing catastrophic risk (20%).¹⁰ Because government spending is not increasing at pace with population growth, households are forced to share an increasing burden of financing health care, which puts the poor and lower income groups at risk of incurring catastrophic health-related expenditures. More than four percent (4%) of the population has been pushed below the poverty line (US \$1.25/day) due to these health care payments.¹¹ Studies have shown that households in Uganda cope with these OOP expenditures through depletion of savings and selling of assets, including some households being driven into debt.¹² OOP payments for health care also increase socio-economic inequality across the population. Had it not been for the rapid influx of donor funds, OOP levels would be higher.

Translating OOP expenditures to a household level, Figure 4.9 reveals that it has increased in the last six years from twenty-one dollars (US \$21 USD) to twenty-three dollars (US \$23). The NHA 2011/12 also analyzed per capita OOP by income groups. As expected, the higher income groups spent more on health per capita than the lower income groups. However, the report also revealed that **all** income groups experienced increased health expenditures and posits that increased spending may be attributed to the relatively poor quality of health services in public facilities compared to private facilities.

Figure 4.9 Per Capita OOP Uganda (2008 – 2013)



Source: NHA 2011/12

Figure 4.10 shows which service providers households seek healthcare and spend their health money. More than two thirds (68%) of all OOP expenditures are spent in private facilities, which includes private drug stores, pharmacies, clinics and hospitals as well as PNFP facilities. One quarter of household OOP is spent in public health facilities. As the NHA 2011/12 report notes, this is significant (MoH, 2013) given the abolishment of user fees at public health facilities in 2001.

¹⁰ WHO, 2010. Exploring the thresholds of health expenditure for protections against financial risk. WHO Report (2010) Background Paper # 19.

¹¹ Kwesiga B, Zikusooka CM, Ataguba JE. Assessing catastrophic and impoverishing effects of health care payments in Uganda. BMC Health Serv Res.

¹² Leive A, Xu K: Coping with out-of-pocket health payments: empirical evidence from 15 African countries. Bulletin of the World Health Organization 2008, 86(11): 817-908

The majority of these households represent the lowest income groups (HSA, 2011). Evidence suggests that increased private expenditure on drugs and hospital/clinic fees somewhat offset the marginal impact of the abolition of user fees on OOP expenditures by households (Okwero et al. 2010).

Figure 4.10 OOP by Service Provider

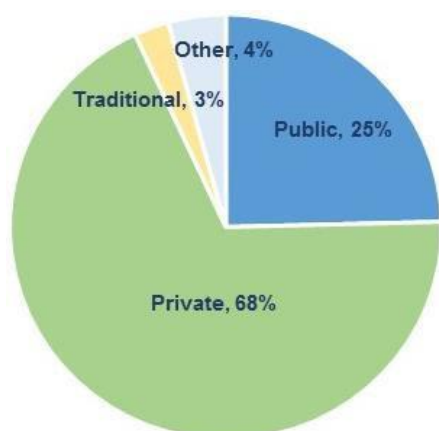
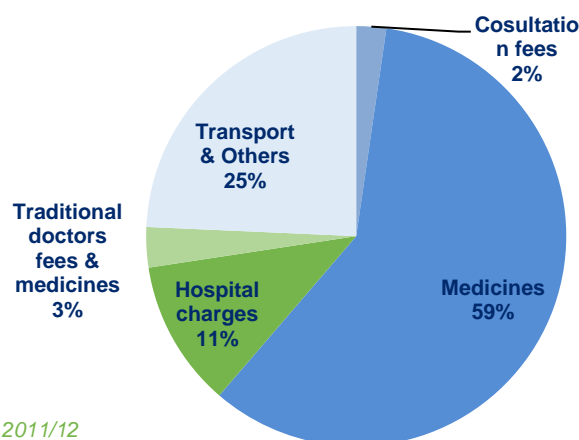


Figure 4.11 OOP by Goods and Services



Source: NHA 2011/12

As Figure 4.11 shows, more than half (59%) of OOP is spent on drugs, reflecting the MoH challenges in medicine stock-outs and non-functional labs. As a result, health consumers who would normally get their drugs for free in the public sector are forced to pay market rates for their medicines in a private retail facility, underscoring the need for a purchaser-provider split for a more efficient health system. It is interesting note that more monies are spent in getting to and from a public or private health facility (25%) than in consultation fees for a private consultation (2%).

4.3.4 Pooling of Health Funds (Insurance Schemes)

In contrast to paying providers for health care directly, pooling resources to cover health expenditures offers the possibility of spreading the risk of incurring health costs across a group of people. Pooling can contribute to equity and access if the health members of the pool subsidize the sick, and the wealthy subsidize the poor. Aside from the equity benefits, pooling resources can create efficiencies in health markets by increasing competition, containing costs e.g. through the use of diagnosis-related groups (DRGs) and encouraging adherence to quality standards. Currently the main pooling mechanism in Uganda is government funds raised by taxes and on-budget donor support (see Figure 4.3).

Most Ugandans seeking healthcare in the private sector do not have access to risk pooling mechanisms. The only prepaid funds for Uganda’s health sector are those from GOU, private health insurance, and the few existing voluntary and community based health insurance (CBHI) schemes (Orem, 2009). Some private commercial schemes exist for the formal sector but these are financially out of reach for most Ugandans and they cover only a small proportion of the formally employed population.

National Health Insurance

For the last two decades, health officials and political leaders have pondered the introduction of a national health insurance fund. In 2006, the GOU asked the MoH to design a health insurance scheme at which point in time, the Minister established a national task force on health insurance to draft a Bill, which was first tabled in 2009. Parliament redrafted the National Health Insurance Bill in 2014 but Cabinet has yet to approve it. In its current form, the Bill states that the GOU will provide subsidies for the indigents in the initial years. Some of the stakeholders interviewed expressed reservations about the capacity of any ministry to manage the funds and strongly felt the Insurance Regulatory Authority (IRA) should manage it. However, this would pose a conflict of interest as IRA should not supervise and manage the scheme.

Under the bill, formal sector employees and their employers will be responsible for paying 8% of the employee's salary as premium into the fund.

Box 4.1 Overview of Proposed NHIS

The scheme plans to initially enroll all public employees and after three years enroll formal private employees. Thereafter, it will gradually enroll informal workers, obtaining 100% enrollment in 15 years. Employees will contribute 4% with a 4% match from employers to fund the NHIS. The private employer will pay the match while the government will pay for public employees. The NHIS design estimates that 19% of the population is considered the poorest of the poor. Government and/or donor funds will pay the premium for this group and until the NHIS is up and running, the poor can access free health services at public and PNFP facilities, while private employers can voluntarily offer private health insurance

The NHIS will offer a defined basic care package to the insured and four dependents. Health services will be delivered by MoH, PNFP and PHPs, which the NHIS will purchase using a combination of different provider mechanisms including fee-for-service, capitation and/or a combination.

The roll out of NHIS will be phased. Initially the scheme will be offered to public servants, then later to those formally employed in the private sector, and finally to the informal sector employees. The initial plan is projected to cover approximately two million employed Ugandans (6% of the population) and later transition to cover other voluntary members.¹³ The fund will use the national ID system as the unique identifier and will tap into existing CBHI schemes, Savings and Credit Cooperative Organizations (SACCOs) and Village Savings and Loans Associations (VSLAs).

There is still considerable debate whether the government will move forward with the NHIS Bill. Approximately half of the stakeholders interviewed for the PSA expressed optimism that NHIS would be introduced soon and suggested it could even be included in the fiscal year 2016/2017 government budget. However, an equal number of interviewees doubted government's willingness and commitment to set up the fund. These same key informants pointed out that the proposed bill in its current form still harbors several technical impracticalities, specifically:

- Given the extreme inequalities in access to health care, analysts suggest that gradual implementation and low coverage will take too long to finally reach those who need the insurance plan most – the informal sector – which is scheduled to be the last beneficiary group (Orem, 2009).
- The most eligible providers – both public and private providers – are concentrated in urban and peri-urban areas, further perpetuating the existing disparities in access to service delivery (Orem, 2009).
- The fund provides no co-pay option for beneficiaries with no provision to address the issue of overutilization that currently plagues many of the commercial health insurance providers in Uganda.
- There is no consensus amongst MoH and other stakeholders on whether a NHIS Fund is the best way to achieve equitable health care for all Ugandans.

The public is also not fully supportive of the NHIS proposal which may be attributed to poor publicity and limited efforts to sensitize the public. Some individuals have perceived the NHIS plan as an additional tax on the public; this perception could be due to poor public sensitization. The PSA Team found that only 40% of

¹³ <http://healthmarketinnovations.org/program/national-health-insurance-fund-uganda>

formal sector employees had heard about the proposed NHIS policy and even those who had heard of it were usually misinformed or unaware of its objectives (Zikusooka et al, 2008).

Given the ongoing debate among policymakers, health finance experts and the public, it is highly unlikely that NHIS will be implemented anytime soon.

Private Health Insurance

Overview of the Insurance Industry. Uganda has an undeveloped but growing insurance market (Carpenter et al, 2014). According to the Uganda Insurers Association, insurance penetration is less than one percent (1%) of the entire population. In addition, insurance coverage in Uganda is much lower compared to Kenya (3.2%) and the African markets as a whole (3.6%) - Carpenter, 2014. Most of these insurance schemes are found in urban areas, target the formal employed and are mostly available to the urban affluent.

General business and life insurance represent the largest share of insurance policies written in Uganda (see Table 4.5). Health insurance represents less than a third of premiums sold and this number may even be an overestimate. Stakeholders interviewed state that many of the individuals covered have multiple policies including health. Over half (53%) of total gross premiums written that are **not** life insurance policies are generated by three companies (Liberty Life, Jubilee and AIG) while the smallest five companies account for less than 4%. The top four players (ICEA, UAP, Jubilee and National) capture seventy-two percent of gross premiums for life insurance policies (Carpenter et al, 2014). As a result, the market is highly fragmented among small players who are competing for small market shares left by the top four players. Competition is fierce, focused on price and not product invocation.

Health Insurance. There are over 20 licensed commercial insurance firms in the country of which five provide private health insurance (see Table 4.7). Few insurance companies offer health insurance, possibly due to the complexity of this type of insurance product. Stakeholders interviewed stated that the consumer market is small. The total number of health insurers has remained more or less constant over the last ten years. There has been some “churning” in the health insurance market place; since 2008, three insurance companies have left the market (Micro-Care, East African General Insurance, and Paramount) while five new companies have been licensed (PAX, APA, Britam, Sanlam Life and Nova).

Table 4.7 Selected Private Health Insurance Companies and their Benefits Package

Company Name	Summary of Health Benefit Package	Illustrative Prices
Sanlam Uganda	In patient services, external medical appliances, dental, optical, maternity, specialized radiology, private nursing and hospice services, last expense benefits.	5,171,307 per family
Insurance Company of East Africa (ICEA)	In patient services, external medical appliances, dental, optical, maternity, last expense benefits.	745,750 per individual
Jubilee Insurance	In patient services, external medical appliances, dental, optical, maternity, specialized radiology, last expense benefits.	990,495 per individual
Liberty Health (Blue Classic)	In patient services, external medical appliances, dental, optical, maternity, specialized radiology, last expense benefits.	1,204,275 per individual
UAP Insurance Uganda Ltd.	In patient services, dental, optical, maternity, specialized radiology, last expense benefits.	1, 159,459 per individual

Source: Company marketing materials, 2016

In Uganda, three types of entities offer health insurance; private insurance companies, health maintenance organizations, and community-based health insurance organizations (CBHI's)

(see Figure 4.11) and are subjected to different regulations. The Insurance Regulatory Authority (IRA) regulates private insurance companies that carry a medical product and HMO's. Currently, CBHIs are registered and regulated as HMO's. Excluding the number of CBHI beneficiaries, private insurers and HMOs have almost equal shares in terms of persons covered. Both offer their services predominantly in the wider Kampala area (Carpenter et al, 2014).

In Uganda, corporate employers who offer health benefits to their employees and the employees' dependents are the largest purchasers of private health insurance (HFS, 2016). The benefits covered are largely curative, including some in-patient services: 92% of all products available are a combination and range from a basic package charging the lowest insurance premium, to a more comprehensive package that covers dental and maternity care (84%) and the most sophisticated package that includes air evacuation and health services outside the country.

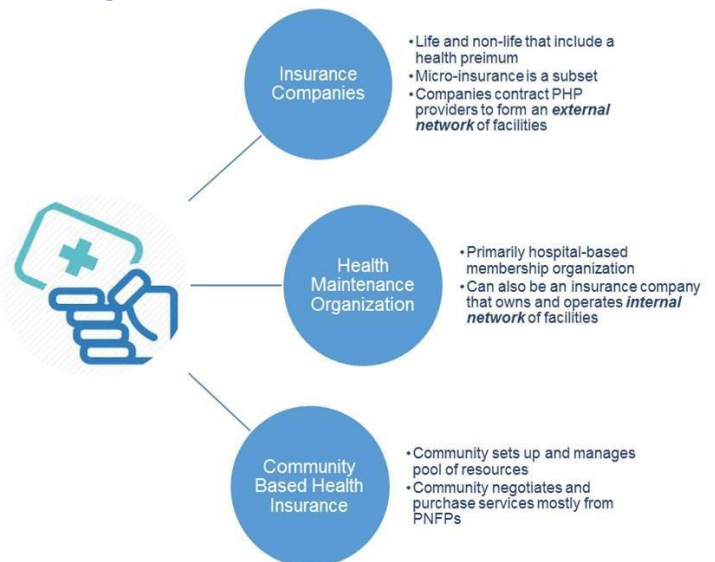
According to the private health insurance companies interviewed, the biggest obstacles facing the growth of private health insurance are, in this order, i) limited market, ii) overutilization of services, and iii) inaccurate recording practices by the health providers. At an average cost of US \$200 per person insured, private health insurance is still prohibitive even for many corporate employers let alone individuals. Instead of private health insurance, some of these employers provide in-service clinics, others have reimbursement arrangements with nearby private clinics, and others simply include a medical expenditures stipend in their employees' salary.

Despite their minimal market penetration and low insurance coverage, the National Health Financing Strategy and the draft NHIS Bill acknowledge the importance of private health insurance. One of the insurance industry's key concerns regarding the proposed NHIS Bill was losing their market share to the scheme. A 2008 study re-enforced these concerns revealing that only thirty-six percent (36%) of surveyed employers would continue paying for private health insurance for their employees if the NHIS materialized (Zikusooka, 2008). Due to this concern, the government has actively engaged private health insurers in the process of developing the NHIS scheme. The government has taken extra steps to reassure commercial health insurance schemes and third-party health administrators that they will not face competition from the NHIS because the NHIS intends to use multiple insurance plans to cover various segments of the population and will potentially become a purchaser of their health insurance product and/or services.

To date, there is no clear, legal definition of micro-insurance in Uganda (Carpenter et al, 2014). Micro-insurance is a more affordable health insurance package designed to target low-income and informal segments of the population.

Although Uganda was one of the first African countries to introduce micro-insurance in 1997, only five of the twenty plus licensed insurers offer micro-insurance (Carpenter et al, 2014). Most micro-insurance is provided through group policies and sold to financial institutions such as microfinance deposit-taking institutions (MDIs), micro-finance institutions (MFIs), SACCOs, and commercial banks (see Section 5 for an in-depth discussion of financial institutions in Uganda).

Figure 4.11 Private Health Insurance Entities



Micro-insurance is dominated by credit life policies and there are few micro-health insurance products in the market place. Despite the interest in micro-insurance, few of the major insurance companies in Uganda have developed a specific strategy to grow this part of their business.

There is a considerable opportunity for micro-health insurance given the size of the potential consumer market, who can afford to pay a low-cost premium. By industry estimates, approximately 43% of the Ugandan population is considered to be non-poor but insecure while another 33% is classified as middle class (Carpenter et al, 2014).

Box 4.2 MyLife: An Example of Micro-Insurance

In 2013, Liberty Life and MCash jointly launched a new micro-insurance product for the urban lower-income group called MyLife. This product offers compensation in case of personal accidents and hospitalization. The product targets the boda-boda drivers and their families and has three benefit levels:

- **Silver:** UGX 1.0 million maximum coverage for a UGX 2,550 monthly premium
- **Gold:** UGX 2.5 million maximum coverage for a UGX 6,250 monthly premium
- **Platinum:** UGX 5.0 million maximum coverage for a UGX 12,250 monthly premium

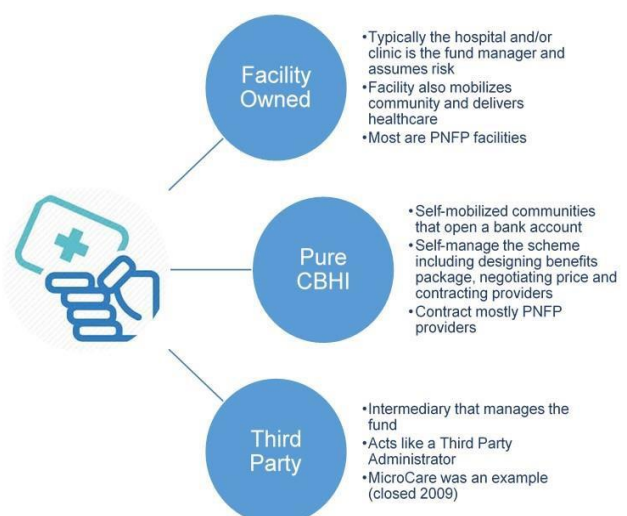
Events covered include accidental death and permanent disability as well as hospitalization exceeding 72 hours. The product is sold exclusively through MCash agents who are fully trained and licensed by the IRA as insurance agents for Liberty Life. All premiums are collected through MCash, a provider-agnostic service. (Source: Carpenter et al, 2014)

Challenges Facing Formal Health Insurance. The health insurance industry, and micro-insurance in particular, face several challenges to growth: i) the public does not understand the concept of insurance and its benefits; ii) the public do not trust insurance companies; iii) Ugandan insurance companies do not have experience or skills needed to develop micro-insurance products; iv) the traditional broker/agent sales model will not work outside of Kampala; v) and severe undersupply of qualified medical providers, supplies and equipment outside of Kampala. Growing this segment of health insurance will require designing products that address the financial limitations of the target population, innovative solutions to address gaps in providers particularly outside of Kampala, and creative solutions to encourage both beneficiary enrolment and private provider participation.

Community Based Health Insurance

Overview of CBHI in Uganda. CBHI has been in practice for over three decades in Uganda. Initially, communities created “burial groups” to collect money for burial. Eventually the communities decided to collect money to prevent burials and instead pay for health care of the sick. The practice started in mostly rural areas with membership being voluntary but has replicated to more parts of the country. Most of these schemes are concentrated in south-southwest and central regions. An umbrella association - Uganda Community Based Health Financing Association (UCBHFA) - represents the CBHIs. The group is not well funded but works to increase transparency and share lessons learned from different CBHI schemes.

Figure 4.12 Types of CBHIs



There are three types of CBHIs in Uganda; i) facility-owned ii) pure CBHI and iii) third party insurance. Most of these schemes are hospital-based (primarily with PNFP facilities) and managed the respective communities (see Figure 4.12). Very few CBHIs have hired a Third Party Administrators (TPAs) to manage their schemes.

A 2015 inventory by UCBHFA shows that there are 23 member schemes in about 17 districts. Their sizes vary from as few as 180 to 36,000 members. (See Table 4.8 for a list of these schemes, benefit packages and prices.) The CBHI benefits mostly cover in-patient care, outpatient care, minor surgeries, and tests. The schemes collect information on beneficiaries' incomes, conduct hospital surveys on service utilization and frequency of visits within nearby health facilities to set premium prices. For an average of US \$6.00 per head, one receives a full range of services for the commonly occurring ailments within the scheme's area of operation.

Table 4.8 Summary of Existing CBHI Schemes under UCBHCA, 2016

Scheme	District of Location	Beneficiaries by 12/2015
Kisiizi Hospital	Rukungiri	36,500
Bushenyi Medical Centre	Bushenyi area	11,533
Kabwohe Clinical Research Centre	Sheema	2,885
Kibirizi sub scheme	Rukungiri	15,833
Kinanira	Kisoro	
Kitanga	Kanungu	
Mutolere	Kisoro	
Nyakibare	Rukungiri	
Nyamwegabira	Kanungu	
Ishaka Health plan	Bushenyi	
Mitooma Central Clinic	Mitooma	425
Happy Health Insurance	Ntungamo	183
Uganda Health Cooperatives	Bushenyi and Sheema	5,493
Bwindi community hospital / e-Quality	Kanungu	23,069
Kathel Medical Centre	Mbarara	1,330
Katungu Mission Hospital	Bushenyi	18,623
Nyakatsiro Health Centre	Mitooma	577
Comboni Hospital	Bushenyi	3,258
ICOCARE/ ICOBI	Sheema	1200
Bushenyi Rural Development Organization	Bushenyi	289
Munno mu Bulwadde Union of Schemes Organization (MBUSO)	Luwero, Nakasongola, Nakaseke,	21,254
Save for Health Uganda (SHU)	Bushenyi, Sheema, Mitooma, Kampala, Wakiso	6,014
TOTAL		149,757

Source: UCBHCA, 2016

The majority of CBHIs are affiliated with a PNFP facility and some to a private wing of a public health facility ranging from HC II to hospital levels. Scheme managers interviewed noted that very few PHP's participate in CBHIs for a variety of reasons including low reimbursement levels and difficulties in sustaining quality services – an important attribute in attracting and keeping CBHI members enrolled in a scheme.

A Cordaid/UCMB 2009 review found communities experience several benefits under a CBHI plan. They reported a reduction in catastrophic health expenditures in households enrolled in the scheme.

Members also did not delay in seeking healthcare and the relationship between communities and health providers improved significantly once the community participated in health facility decision making. However, mixed experiences as demonstrated by a case example in Luwero exist (see Box 4.3).

Box 4.3 Save for Health Community Health Benefit Plan

CBHIs vary in terms of coverage, experience and focus. One example is “Save for Health” CBHI in Luwero. The group offers a three-tiered health insurance product to its members: zero deductible, mid-range deductible and a high deductible plan. As each deductible increase, the premium is reduced. Premiums must be paid in advance.

Save for Health sensitized the community to the benefits of health insurance, but the CBHI has not been able to secure a steady supply of qualified healthcare providers and transportation costs – not included in the benefit package - are an economic barrier to seeking healthcare. For example, an individual may not want to pay 20,000 UGX to receive treatment that only costs 4,000 UGX.

The plan has experienced a 21% loss in membership. Reasons for non-renewal include high price of premium, limited access to providers and low levels of client satisfaction.

(Source: Carpenter et al, 2014)

The same report acknowledges CBHI coverage is low and that there are several challenges to scaling up CBHI. The key informant interviews confirmed these findings:

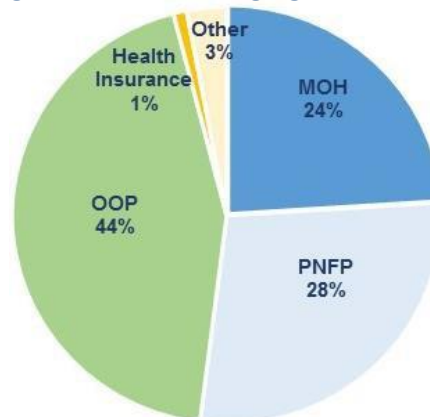
- Lack of political will in supporting CBHI, particularly while the NHIS is being debated. The MoH plays a minimal role in promoting and regulating CBHI schemes. Currently, there are no regulations governing CBHI schemes. As a result, the community based organizations managing CBHIs are treated as commercial private health insurers. Moreover, CBHI schemes receive no government funding and are mostly donor dependent (Orach, 2014).
- The MoH acknowledges the importance of CBHIs, as demonstrated by their inclusion in the HFS and proposed NHIS Bill. Indeed, CBHIs are recognized as one of the many possible health insurance mechanisms under the umbrella national health fund. But there are no provisions in either of these policies to fund CBHIs despite their focus on the poor (Orach, 2014).
- Poor penetration/enrolment because many community members cannot afford to pay the premiums. Several key informants noted they often have to set their premiums lower than the calculated premiums due to the beneficiaries’ low-income levels and inability to pay for health services. Moreover, many of the beneficiaries struggle to keep up with the payments because their income is seasonal (e.g. for farmers). In some instances, beneficiaries make in-kind contributions. To help address these economic barriers, several CBHIs offer flexible payment terms to attract and retain members.
- Premiums are too low to make CBHI financially sustainable and viable insurance mechanisms. PSA key informants noted that premiums for such schemes have hardly increased over the past 15 years. They range from US \$4.00 – 7.00 per person per year. Most of the schemes are small with enrolment numbers ranging from a few hundred to tens of thousands per scheme. Because of the reluctance to increase premiums, the funds collected do not fully cover operational and administrative costs (Orach, 2014).
- Competition from public health facilities. Promoting CBHI’s would understandably be at loggerheads with the free health care policy, as the government is supposed to provide all health services free of charge in public health facilities.

In order for CBHIs to play a more significant role in health service delivery, they will have to evolve from their current status of operating under the radar to receiving full government recognition and proper regulation (Basaza, 2010).

Strategic Purchasing

There are multiple purchasers of health care services in Uganda; namely the public sector through the MoH and local governments, PNFPs, households through direct OOP payments and health insurers. Figure 4.14 shows the distribution among these different groups. Despite the MoH’s mandate to focus more on stewardship and governance, the MoH has not operationalized the purchaser-provider split and still functions as both the provider and purchaser of services in the public sector (HFS, 2016). However, MoH is experimenting with a number of purchasing arrangements of which a few show great promise in moving towards a purchaser-provider split and helping build a sustainable network of private providers. These mechanisms include the Primary Health Care (PHC) Grant, Results Based Financing (RBF) and Reproductive Health Vouchers (RHV).

Figure 4.14 Purchasing Agents in Health

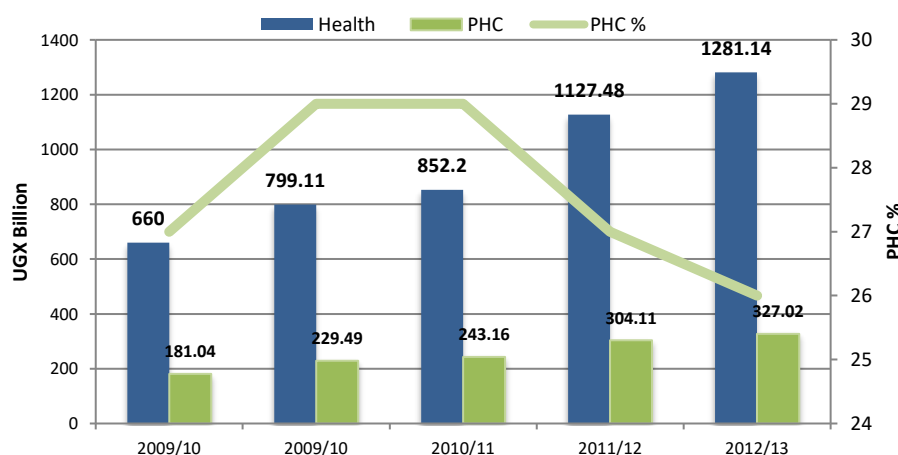


Source: NHA 2011/12

4.3.5 The PHC Grant as a Mechanism to Purchase Health Services

In recognition of the PNFPs’ contribution to health, the government subsidizes PNFP facilities in the form of Delegated Funds under the PHC Conditional Grant (referred to as the PHC Grant). This is a recurrent non-wage grant channeled through local governments, initially given to hospitals in crisis, and subsequently widened to include all PNFP hospitals and lower level health centers. The PHC continues to grow: In 2001/02 the grant was extended to PNFP Training Schools; in 2002/03, the MoH budget formalized a wage subvention for PNFP facilities to pay seconded medical officers; and, in 2003/04, the government introduced a medicines credit line allowing PNFP hospitals and health centers to purchase medicines and supplies using credit.

Figure 4.15 PHC Funds as Percentage of Total Health Allocation, 2009/10-2012/13



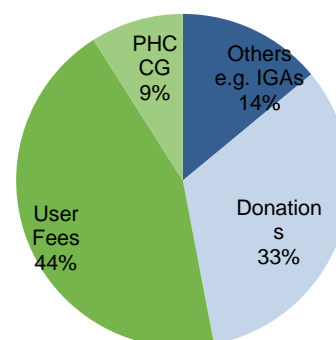
Source: AHSPR 2014/15

According to the MoH Annual Health Sector Performance Report 2014/15, there has been steady increase in PHC wages over the past five years with no significant increase in the remaining components of the non-wage PHC Grant (see Figure 4.15). The result shows an overall increment in PHC allocation. The lack of relatively commensurate to investments with non-wage allocation has resulted in insufficient funds to cover : i) additional staff recruited to keep pace with increased demand, ii) recurring associated with maintenance of an old and decaying infrastructure, iii) capital costs to expand and/or rehabilitate hospitals and to purchase new medical equipment and iv) extraordinary expense to carry out immunization outreach. This affects the productivity at the health facilities, governance issues notwithstanding. Excluding medicines and health suppliers, PHC grants represent 30% of the total health sector budget.

According to the latest projections available from the MoFPED, the PHC Grants will not increase in the next two fiscal year (FYs) (stakeholder interviews). As Figure 4.15 demonstrates, although the total MoH allocations have increased since 2009/10, the percentage allocated to PHC Grants has declined over the years. Allocation of PHC Conditional Grants per facility is dropping due to stagnated total grant contributions combined with increasing number of PNFP facilities. In 2014/15, a typical hospital received, on average, 170 million per year while lower level facilities received UGX 7.3 million. This average contribution is considerably lower than 2003/4 levels in which a hospital received UGX 296 million and lower level health facilities, UGX 10.4 million.

The PHC Conditional Grant covers approximately 9% of a PNFP health facility’s costs (see Figure 4.16). The percentage varies depending on the PNFP facility location and level. The facilities have to find other financial sources to cover the rest of the costs of services. Donor funds make up 33% but as noted the majority of these funds are earmarked for HIV/AIDS, TB and malaria programs (Orach, 2014). Moreover, these vertical programs weaken PNFPs’ governance and management of their network of facilities (key informant interviews).

Figure 4. 16 Financing of PNFP Facilities, 2013/14



Source: Orach 2014. JRM Presentation

PEPFAR funds are earmarked and do not allow PNFPs to charge a fee to administer the funds and drugs associated with PEPFAR projects.

In light of increasing demand of health services, PNFP facilities are increasingly reliant on user fees, which contribute 44% of PNFP financing (Orach, 2014) This runs contrary to all PNFP-stated missions to deliver affordable health services for the underserved and poor.

Interviews with PNFP/medical bureau administrators revealed the limitations of the PHC Grants as a means of financing PNFP facilities. The grant’s input-based approach uses different formulae to allocate funds to PHC non-wage, PHC wage and PHC development activities. A significant proportion of the resources is earmarked, are not fungible, and do not allow the bureaus to use them as needed (Okwero et al, 2010). As noted before, donor funds are also severely restricted. The lack of funding flexibility does not allow the bureaus to invest in their roles as managers of a vast network of health facilities. A few of the bureau administrators felt that the MoH (and donors as well) receive several benefits from PNFPs – regulatory compliance, quality guideline adherence, CPD training, and supportive supervision guidelines – yet they did not pay for them. In addition, the PHC grant is inefficient funding mechanism in that it is not linked to performance outcomes nor related to true costs of delivering the health services required by the MoH.

Bureau administrators expressed an interest in moving away from PHC Conditional Grants to a more realistic funding mechanism such as service contracts that are outcome based. They consider service contracts reflect the true costs to deliver health services and products as well as incentivize PNFP facilities to continue strengthening quality and efficiencies. Some of the interviewees shared that being paid for performance will enable PNFP facilities to reduce user fees drastically, if not completely. Others expressed a growing concern that some segments in the MoH leadership are reluctant to continue funding PNFP services through the PHC Grants because they view PNFPs as competitors and do not share a vision that strengthening PNFPs is also strengthening the overall health system – a view also expressed in a bureau report (Orach, 2010¹⁴).

4.3.6 Nascent but Promising Experience in Performance Based Financing

Over the last decade, a number of performance-based financing (PBF) schemes have been implemented in Uganda to improve health systems performance. To date, these initiatives have remained pilots, not gone to scale or been integrated into the overall health system. Given the positive experience, the MoH has formed a National RBF task force to spear head the development of a national RBF framework.

Uganda Catholic Medical Bureau (UCMB) PBF Experience

One of the most documented PBF experience is the UCMB PBF Project. With assistance from Cordaid, the three-year pilot aims to improve access to quality healthcare services. The pilot is located in the Kamuli, Namayingo, Jinja, Mayuge and Kaliro Districts in the Busoga Region. There are sixteen PNFP and four public facilities participating in the PBF pilot.

The PBF pilot is a partnership between UCMB under the Jinja Diocese and the DHMT under the leadership of the District Health Officer. Each partner had clear and specific roles and responsibilities: i) the Diocese of Jinja is the purchasing agent; ii) the DHMT is the regulator, responsible for quality assessment and verification, and; iii) CBOs are consumer advocates and conduct data verification at the facilities on a quarterly basis; iv) the District PBF Steering Committee provides oversight to the whole program.

Unlike other PBF interventions as examples of mechanisms of purchasing health services, the PBF pilot in Jinja incentivized health workers to provide specific health services that meet quality standards. The PBF focused on outpatient consultations, and a range of maternal, reproductive and child health interventions. Table 4.6 lists the bonus amount by service.

Table 4.9 PBF Services and Bonuses

Service	Bonus UGX	Bonus US \$	Facility Level
Outpatient consultation	500	.15	All
1 st ANC visit	1,000	.30	All
All 4 ANC visits	3,500	1.05	All
AN: IPT2	1,000	.30	All
Institutional delivery	25,000	7.50	All
Referral EMONC for pregnant mothers	10,000	3.00	All
Short-term FP method (injectable/orals)	1,000	.30	All
Long-term FP method (implant/IUD)	1,000	.30	All
Children fully immunized	3,500	1.05	All
Caesarean Section	70,000	21.00	HC IV / Hospital

Source: Cordaid

¹⁴ Presentation to Geneva Health Forum 2010: The PNFP Sector in Uganda, a Life Under Threat

The pilot demonstrated that a sophisticated purchasing system such as PBF can be successfully implemented within the institutional arrangements of the Uganda health sector and that there are best practices (see Box 4.4) that lead to greater likelihood of success. After three years, the pilot yielded concrete results that contributed significantly to better health outcomes in the region.

- 29% increase in new out-patient consultations
- 67% increase in completed ANC visits
- 69% increase in deliveries attended by skilled health workers in a health facility
- 6% improvement in quality of care in PNFP facilities and 18% in MoH facilities
- 87% overall patient satisfaction in the last 6 months

Box 4.4 Factors Contributing to Successful PBF

There is growing experience of PBF used in the social sectors of developing countries. As the Cordaid experience in Uganda and elsewhere in SSA region demonstrate, there are six factors that increase the likelihood of both strengthened systems and improved health outcomes. They include:

Linking payment to performance. PBF schemes balance quantity and quality and pay not only for service delivery targets but also quality indicators. The scheme specifies payment per outcome – *not* fee-for-service.

Integrating sound contracting principles. At the heart of PBF is a contract between purchaser and provider. A contract clearly outlines expectations, roles and responsibilities. Governments contract *both* public and private facilities to maximize access.

Separation of functions. PBF is often regarded as a first step in creating the purchaser/provider split in health. Purchasing is independent from both provider and regulator under PBF. The purchaser verifies before paying. External entities, such as CBOs and universities audit PBF schemes.

Provider autonomy. Healthcare providers under a PBF scheme need autonomy and capacity to make strategic decisions regarding hiring and firing, managing finances and purchasing supplies/equipment to improve services. They also need financial independence through sufficient reimbursement levels and predictability of payments.

Community empowerment. PBF schemes also have mechanisms by which to engage all relevant actors (e.g. MOH, professional associations and consumer groups), solicit community input and feedback and measure consumer satisfaction.

Equity measures. PBF schemes also help reduce OOP and catastrophic expenditures with demand side strategies (e.g. vouchers) and supply side (e.g. insurance, grants, subsidies and contract) to remove economic barriers to healthcare.

Source: Cordaid presentation on PBF, 2014.

Proposed National RBF Framework

PBF is a cornerstone reform mechanism under the Health Financing Strategy and the MoH has developed a draft national RBF which is currently under review. The draft proposal integrates many of lessons learned from Jinja Diocese and others with extensive experience in RBF/PBF. Highlights from the draft RBF framework include:

- Establishing a purchasing unit in the MoH and developing its capacity to purchase health services;
- Implementing a “hybrid” model of purchaser/provider split where the MoH will regulate, purchase and deliver services;
- Moving from fee-for-service towards output-based provider payment modes;
- Scaling up RBF in all public health facilities to enhance efficiency;
- Using RBF with both PNFP and PHPs to purchase services complementary to those offered by the MOH; and
- Rolling out RBF systematically and progressively to cover the whole country by the end of the HFS period.

The draft framework is still under review. The BTC-funded PNFP Project is providing technical assistance to establish RBF and financing to fund RBF in West Nile and Rwenzori Regions.

4.3.7 Growing Experience in Vouchers

In 2006, the Uganda MoH launched its first Reproductive Health Voucher Programs with funding from the German Financial Cooperation (KfW)¹⁵. Today there are several voucher programs – most notably the World Bank and USAID reproductive health voucher programs. These programs are implemented through partner organizations – not the MoH – such as Marie Stopes, Baylor Uganda and Abt Associates (See Box 4.5). Currently the World Bank Voucher program focuses in the Western and East Central regions covering 14 and 12 districts respectively while the USAID Voucher program focuses in the East and Northern Regions.

Box 4.5 Overview of World Bank and USAID Voucher Programs

World Bank

The Uganda Reproductive Health Voucher Project (URHVP) became effective on 2 September 2015. It is a results/output based aid project financed by a \$13.3 m SIDA grant channeled through the World Bank/ Global Partnership on Output-Based Aid (GPOBA). The Project objective is to increase access to skilled care among poor women living in rural and disadvantaged areas during pregnancy and delivery. It involves both public and private health providers. The Project is currently being implemented in 14 districts in the South Western and 12 districts in Central Eastern regions

UNFPA provided an additional \$954,436 for RH voucher scheme for Eastern Region and bringing on board 3 more districts. 1 district already on selected and the 2 to be identified. Marie Stopes Uganda and BDO were contracted by MoH as the Voucher Management Agency (VMA) and Independent Verification and Evaluation Agent (IVEA) respectively. The Project has 2 components: Component 1: Provision of 132,400 pregnant women access to a defined package of safe delivery services from contracted private and public providers which includes; (i) Service provider selection, (ii) Voucher service pricing and Voucher Service Provider contracting and (iii) Voucher service provision and Component 2 focuses on Capacity building and project management

USAID

Abt Associates is implementing a five-year Uganda Voucher Plus project worth \$24m to improve service delivery through the private sector in Uganda. The program will be implemented in two regions – far Eastern and the Northern region. The voucher program will contract both PFP and PNFP providers to achieve 250,000 safe deliveries. Providers will be reimbursed for delivering a range of reproductive and maternal health services including 4 ANC visits, safe delivery, 1 post-natal visit and post-delivery FP method of their choice. There is also a demand generation component. Each contracted private facility will have 2 “mobilizers” who conduct community outreach and drive foot fall to the clinics. The mobilizers will sell the vouchers to mothers at Ushs 4,000 and keep a margin of Ushs 2,000 as their incentive.

Typically, vouchers address demand side barriers to maternal health services. They cover a wide range of reproductive and maternal health services including ANC visits, PMTCT services, safe skilled delivery, EmOC services, postnatal care and treatment and diagnosis and treatment of STI diseases. Contracted providers are reimbursed based on the number of services they deliver. To date, most of the voucher programs in Uganda have been implemented in public and PNFP sites but the government is currently working with the World Bank to scale-up the voucher program countrywide including PHP facilities.

The contracted private health providers that the PSA Team interviewed shared that they greatly benefitted from participating in the voucher programs. They were grateful for the quality improvement they received from such trainings, clinical updates and supportive supervision.

¹⁵ Grainger C. et al, 2014. Lesson from Sexual and Reproductive Health voucher program design and function: a comprehensive review.

They also reported increases in revenue from both voucher sales and the ancillary services that voucher clients sought. However, it was observed that non-participating PNFP and PHP providers experience a down turn in their client volumes. Other challenges include non-utilization of the purchased vouchers for reasons such as long distance to health facilities and transport difficulties among others (World Bank, 2012).

Both the literature and country program reports have demonstrated that voucher programs are effective. The Ugandan voucher programs have increased the uptake of maternal health services by as much as 9% in their areas of implementation.¹⁶

In 2011 alone, over 50,000 vouchers were sold in Uganda with over 80% of these being redeemed for the delivery portion of the voucher service package.¹⁶ A 2012 World Bank report found that of the 102,562 vouchers sold in its three-year program, 85% of pregnant women used them for at least one antenatal care visit. The same report also found a high rate of uptake for deliveries; 64% of vouchers sold were redeemed for facility deliveries. These findings, in addition to numerous studies, have found that vouchers are cost effective in overcoming barriers related to accessing maternal and child health services for the indigent. The evidence also shows that they promote equity in access to health services and can lead to improved quality of care.¹⁷

4.4. Key Findings on Health Financing

- 1. Current funding levels are insufficient to ensure quality and achieve UHC.** Although government spending on health has increased, per capita spending remains low by WHO standards. At its current per capita health expenditure level of \$52 USD, the achievement of UHC in Uganda will remain a challenge since WHO estimates that it will require sixty dollars (\$60 USD) to delivery essential health services in a developing country.
- 2. The Ugandan health system is overly dependent on donor funds and OOP to finance health care,** calling into question the system's overall sustainability and underscoring the great inequities in access to health services and products. Development partners are the primary source of funds for health in Uganda. Their contribution is 46.3% and primarily reliant on one source – USG – raising the question of what will happen when PEPFAR funds are withdrawn, as Uganda aspires to become a middle-income country. Individual households are the second source of health financing in Uganda (37%). Reliance on household expenditures is widely recognized as an inequitable way to finance health, often resulting in catastrophe and/or impoverishment. Government spending has declined over the years from 18% to 15% of THE for the period 2000-2012, and has remained at this level for the last decade.
- 3. Government, donors and households fund different activities in the health system,** further fragmenting and not creating efficiencies in financing health. Government funds focus mostly on financing the network of public health facilities and staff. Three-quarters of donor funds are spent on curative care, particularly in the area of HIV/AIDS and TB, while less than one quarter was spent on prevention. Prevention funds are spent on, in order of priority, disease control programs, information, education and communication, and finally immunization.

Households, mostly low-income ones, spend their OOP on both public and private services and products (30/70 split). One of the reasons why individuals pay high OOP in a public facility despite the abolishment of user fees is the lack of medicines and health supplies, requiring patients to purchase goods and services in private facilities. Almost two-thirds (59%) of OOP funds are spent on medicines, reflecting the MoH challenges in medicine stock-outs and non-functional labs. It is interesting to note

¹⁶ African Strategies for Health, 2015. Cost-effectiveness of RH Vouchers and CBHI in Uganda. USAID Technical Brief.

¹⁷ KFW, 2011. RH Voucher Programs in Kenya and Uganda. Position Paper.

that more monies are spent in getting to and from a public or private health facility (11%) than in consultation fees for a private consultation (2%).

4. **It is unclear if there is sufficient political will to address the health financing challenges in the near future.** As the interviews with government stakeholders revealed, there is still considerable debate whether the government will move forward with not only the NHIS but also the HFS (See Box 4.5). On one hand, several stakeholders expressed optimism that the NHIS will be introduced soon while on the other hand, many expressed doubt on the government's commitment. The MoH envisages that the HFS that was finalized and approved by MoH Top Management in March 2016, will serve as a catalyst to address gross public under-funding of the sector and inequitable financing.
5. **There are limited financing options to incentivize the private sector to grow the private health industry or to expand essential health services to underserved geographic areas,** especially with the uncertain future of a NHIS. The private health insurance market is small, has already saturated its target consumer group and competes intensely for the small number of potential clients. The only way for private health insurance, in the absence of a NHIS, is to go "down" market with low-cost insurance programs that will penetrate middle class and low-income earners including those in the informal sector. Currently, there is a small number of CBHIs covering a small number of beneficiaries. The private health insurance industry experimented with micro-insurance but failed.
6. **The current financing mechanisms – vouchers, grants and service contracts – limit, not encourage private sector growth.** Both the World Bank and USAID voucher programs have geographic restrictions to areas, which parenthetically do not have the largest number of PHPs. The PHC grant is an inefficient mechanism that does not invest in growing or sustaining a critical network of service providers. There is very limited service contracting capacity in the MoH, which could be a strategic tool to motivate private providers to deliver services to underserved population groups.

Aside from the equity and efficiency arguments to implement the HFS, one can add an additional argument that these financing mechanisms *influence private provider behavior in positive ways*.

To date, the MoH has limited but positive experience in service contracting. Purchasing health services through RBF and vouchers – to name a few mechanisms – can become a powerful tool for the government:

- To implement a more efficient way to fund PNFPs when compared to the PHC grant;
- To motivate PHPs to deliver specific services, to specific population groups and even influence them to operate in rural areas;
- To align PHPs activities with UHC, and;
- To link provider payment to adherence to quality standards and levels of performance. It would be beneficial to explore the use of diagnosis related groups in this context.

4.5. Recommendations

The PSA team recommends the following actions to address some of the health financing challenges as well as help create a sustainable private sector that will complement MoH's goal of achieving UHC:

- **Lobby the Ugandan government to move forward with the NHIS.** Although great uncertainty remains on whether the government will act on the proposed NHIS, health insurance is a necessary element in every evolving health system not only in SSA, but also throughout the developed world. There is sufficient evidence on what works and does not in rolling out a NHIS in a low-resource country. Both public and private stakeholders can come together to produce the evidence demonstrating both the health and system benefits generated by a NHIS.

In addition to generating the evidence, stakeholders' groups can get organized and form various coalitions comprised of different stakeholders to pressure the government to act on the draft NHIS Bill. The coalitions can also rally the public's support through a full-court press including but not limited to a public awareness campaign, open spaces in the press, as well as policy dialogue between government and consumers.

- **Help the private health insurance market grow.** With the impetus of the NHIS, the government can also create a more favorable policy environment for private health insurance by: i) implementing the new Health Insurance Act that will create the necessary institutional arrangements to not only regulate the health insurance sector but also create the NHIS, ii) creating a level playing field in the insurance marketplace by ensuring private insurance companies and private healthcare providers are part of the NHIS, iii) promoting greater efficiency in private health insurance industry by encouraging larger risk pools, incentives for better contracting, etc. and iv) creating opportunities for private health insurance companies to go “down market” by facilitating them to introduce micro-insurance schemes and/or to compete for contracts to become the insurers for the informal sector under the NHIS.

The CBHIs will also benefit from the proposed regulatory reforms. Their expansion is another strategy to help grow the private health insurance market by making CBHIs more efficient and sustainable. The draft NHIS Bill acknowledges that CBHIs are a precursor for the Uganda NHIS as demonstrated by other SSA country experience in Ghana, Rwanda and Tanzania (Basaza, 2010). CBHIs can help raise awareness on the benefits of health insurance by avoiding catastrophic health expenses and create a pipeline for enrollment for the proposed NHIS, especially among the informal sector (Basaza, 2010).

- **Lobby the MoH to implement the Health Finance Strategy.** The HFS goes beyond risk pooling to address the challenges confronting funding to the health sector. The HFS also proposes increasing government contribution to reduce its reliance on donor funds and establishing a strategic purchasing function within the MoH. Stakeholder groups – both in and out of the MoH – can urge the MoH to approve and accelerate implementation of the HFS.
- **Take “baby” steps in health reforms that create the foundation for national health insurance.** The MoH can begin taking these steps while stakeholders are advocating the government to implement the NHIS. The short and medium-term steps include:
 - **Harmonizing the maternal health voucher programs.** The 2016 HFS for the country acknowledges vouchers as an RBF initiative. Vouchers have been an effective first step towards a NHIS, making it feasible for governments to contract private providers, because they enable provider registration, quality assurance, monitoring and tracking of payments. The PSA Team recommends that the MoH with assistance from the World Bank and USAID programs does the following: i) harmonizes the two programs to assure they cover the same maternal and reproductive health benefits to avoid confusion among consumers; ii) the Voucher Management Agencies (VMAs) use similar approaches for verifying and reimbursing claims to minimize mistakes on both the part of the contracted providers as well as the VMA; iii) establish comparable reimbursement levels (accounting for regional variances in cost) to prevent market distortions. Section 4.4.2 offers a rationale for scaling the Reproductive Health voucher program nationwide.
 - **Implementing Performance Based Financing for health services.** The World Bank is assisting the MoH to develop its PBF interventions. PBF has the potential to become a powerful incentive for the MoH to influence private provider behaviour and to shape specific health markets. The PBF program is in draft form and the MoH is still receiving comments from stakeholders.

The PSA Team recommends that the MoH involves more private sector stakeholders to provide feedback on the current PBF proposal. In addition, we urge the MoH to rapidly conclude and finalize the PBF proposal in the short-term. Some of the proposed modifications to the current PBF design include: i) expanding the PBF program governance structure to include representatives from both the PNPF and PHPs to speak on behalf of their constituents ; ii) removing the transition period and instead establish a clearer purchaser/provider split under the PBF program; iii) establishing clear, consultative processes by which to establish reimbursement levels and design transparent terms for provider payments; and iv) linking supply side financing (PBF) with demand side initiatives (such as voucher mechanisms and awareness raising campaigns) similar to the successful examples of maternal health voucher interventions and performance based contracting in Gujarat, India.

- ***Growing the MoH experience in RBF now and not waiting until all the systems are designed and in place.*** The Jinja Diocese experience has demonstrated to both the government and private providers that RBF can work in the Ugandan context. The MoH can start the RBF process by building on this experience. Although it will take several contract iterations to work out all the kinks in the MoH system and to gain the local experience in how to design, negotiate and manage a performance based contract, the foundation and experience are in place. The MoH can experiment now with smaller contracts identified in the PSA (see HIV/AIDS and Maternal Health recommendations) before going big. In the meanwhile, the donor community can provide the necessary technical assistance for the MoH to: i) quickly establish the institutional arrangements for a Contracting Unit (e.g. regulations, systems, staffing, etc.); ii) design a modern contract and provider payment systems that conform to international best practices (e.g. web-based, streamlined); iii) provide training to MoH staff and potential private provider networks in critical skill areas such as contract costing, skilled negotiation, conflict resolution, partner management and contract evaluation; and, iv) finally mentor both public and private partners through the initial rounds of contracting until they can perform all tasks independently.
- ***Establishing a drug benefit plan for the informal sector*** (See Box 4.6). Another small step forward would be the creation of a drug benefit plan targeted for the poor – either in the form of a health savings plan and/or risk pool depending on the size. As the NHA shows, medicines and other health supplies are the largest contributor to OOP and the most significant driver for impoverishment due to health expenses. We recommend that MoH design and implement a drug benefit plan that will cover a set package of medicines and diagnostic tests (see text box) for below the poverty line population group. Development partners can assist the MoH by initially funding the drug benefit plan and providing technical assistance to design and rollout the plan. To ensure greater access for the poor, we recommend networking drug shops, particularly in peri-urban and rural areas (See section 7 on the proposal to network drug shops).

Box 4.6 Key Features of Drug Benefit Plan for the Poor

Other developing and transitioning countries (Jamaica, Kyrgyzstan) are implementing Drug Benefit Plans as part of social health insurance scheme. While the Ugandan government waits to decide on NHIs, the MOH can start with a Drug Plan. There are some features these plans share:

- Covers a set package of essential medicines (e.g. FP methods including LARC; ORS, ZINC, micro-nutrients; malaria nets and AZT; TB DOTS; and drugs to treat opportunistic infections and manage NCDs).
 - Also includes all childhood and adolescent vaccines.
 - Covers rapid lab kits to test for HIV/AIDS, malaria, and TB.
 - Drug package will be available through a network for drug shops (see Section 7).
 - Drug plan pays a contracted service provider - in most cases a pharmacist or pharm tech and in a few instances healthcare provider - a “dispensing fee” and set price covering the cost of the drug/test. Or MOH can also donate medicines and test kits and only pay the dispensing fee.
 - Drug plan is **only for the poor**. Beneficiaries do not have to pay at point of sales. Non-eligible individuals can participate in plan to access affordable drug prices but must pay dispensing fee and set (in most case lower) medicine price.
 - All drugs are sourced from qualified distributors to ensure quality products and tests. Sourcing with pre-qualified distributors can also help MOH achieve economies of scale to negotiate more affordable price and distribution cost.
 - MOH can outsource plan administration.
- **Leverage financing mechanisms to influence health markets.** In addition to financing benefits, both vouchers and contracts can be used to structure supply by requiring private providers – both PNFPs and PHPs – to join a network entity. In the case of New Zealand and France for example, all PHC providers are required to join a Primary Health Organization in order to be eligible for payment. Vouchers and services contracts, as well as the drug benefit plan, can also help keep health care costs down by moving away from fee-for-service, establishing pricing guidelines for medicines and other key inputs, and negotiating reimbursement levels across the sector. Lastly, issuing multiple service contracts for different service delivery networks to perform the same tasks can avoid unintentional monopolies, encourage customer service and quality as they compete for customers, and drive overall costs down through competition between service networks.

5. MARKET CONDITIONS AND ACCESS TO FINANCE

The most recent data (MoH, 2012) shows that Uganda has approximately 5,229 health facilities (from HC II to hospital the level) covering all districts (see Table 2.4). Of these 2,362 (45%) are privately owned and operated and of these, 1,488 are PHP facilities (see Table 2.5). The PHP sector is however, still a relatively young industry. Dominated by micro, small, and medium-sized healthcare enterprises (MSME) that desire access to finance, many have neither the requisite transaction history with a bank nor an adequate understanding of the basic tenets of lending and borrowing to secure financing. This section explores the market conditions for the private sector and their ability to secure finances to improve health care services.

5.1. Market Conditions for PNFPs and PHPs

The PSA stakeholder interviews at facilities¹⁸ revealed that there are many challenges PHPs encounter when running their healthcare businesses. Key among these is that the current market conditions do not support expansion and long-term sustainability of PHPs.

- **Barriers to market entry are too low.**

A common complaint among the providers interviewed is that the government creates all these regulations but then does not enforce them. As a result, there are many quack healthcare providers and increasingly, quack laboratories (see

“Anyone can claim they are a doctor, put up a sign, and be open for business....it just too easy in Uganda. There are regulations but no one pays attention to them because they are not enforced.”
(PHP, Kampala)

“Everyone knows they are supposed to renew their license. But not everyone does it, particularly in rural areas.” (PHP, Kampala)

Section 8 on Laboratories). These illegal providers compete with licensed PHPs for clients and create a bad reputation for the rest of the PHPs who are trying to adhere to the rules

- **The market is crowded; prices are too low.** Because the barriers to entry are so low, the market is crowded, driving prices down. Although prices are low, input costs to deliver services are high and increasing. Land, equipment, personnel, medicines and medical supplies are the main cost drivers among the PHPs interviewed. The Program’s Costing and Pricing Study revealed that personnel and medicines were the highest cost inputs for PHPs, irrespective of the facility level (USAID/PHS Program, 2014). Most PHPs can only recuperate their costs and make a minimal return through volume (high footfall), which is difficult to achieve due to competition from PNFP, MoH and quacks.

- **No pricing guidelines to level the playing field and protect consumers.** The same Costing and Pricing study showed that costs varied across facility levels and location (e.g. hospitals had higher costs than HC II and similarly for urban and rural). The survey collected price data and found that there was no systematic method to setting prices. Moreover, the prices were not linked to costs. The same was true for setting prices for medicines. The study also showed that donor subsidies in the areas of HIV/AIDS, malaria and TB did decrease prices charged to patients but the PHPs still had much discretion on what they charge (see Section 6 – HIV/AIDS). As a result, there is no rational methodology for setting prices for consultation fees and medicines, allowing PHPs to set prices based on prevailing market prices (e.g. what is my competitor charging) and clients’ ability to pay.

¹⁸ It is important to note that the PSA team focused its interviews towards the small and medium-size health care businesses

- Clients cannot afford to pay.** Another reason why prices are low is affordability (see Text Box). Many PHPs interviewed reported they have multiple cases of clients who cannot afford to pay, presenting a major challenge to the overall sustainability of their facilities. Yet these same PHPs agreed that healthcare is a priority and *“worth every coin spent, even if it comes from their pocket”*. However, this precarious financial situation acts as a damper to investments in quality or expansion because they can barely eke out a living.
- “We do not consider the indirect costs in pricing services because if we did, the treatment would be very expensive and the patients would run away.” (PHP, Jinja)*

“We only charge low prices because our clients are too poor to afford the true cost of services. This is not optimal because we cannot recuperate our costs much less original investment.” (PHP, Jinja)

“You [see], the whole problem starts with poverty... Mothers come with convulsing children with no money. They can't pay. You end up discharging them without asking them to pay. It is a dilemma. (PHP, Jinja)
- Unequal market conditions for PHPs and PNFPs serving the poor.** The Uganda Demographic Health Survey 2011 (UDHS 2011) shows that many PHPs are serving the poor, yet they do not enjoy many of the benefits PNFPs receive for serving the same target population group. PHPs are subject to VAT, pay import taxes on equipment and medicines, and pay income tax. However, many PHPs are not aware there is a tax waiver on equipment and medical supplies. Further, public and PNFP facilities receive public funds and donor subsidies to cover the infrastructure, equipment, personnel and drug costs. Many PHPs said they could not recruit and retain competent personnel because they are paid higher salaries in the public and PNFP sectors due to public and/or donor subsidies. The Costing and Pricing Study showed that donor subsidies for key services such as HIV/AIDS, TB and FP, has crowded-out PHPs in these markets because they cannot compete with PNFPs or MoH facilities offering the same services at a lower cost or free.
 - Current market conditions negatively impact PNFPs long-term financial sustainability.** The medical bureaus and PNFP providers interviewed acknowledge and appreciate the government benefits such as tax relief, funds through the PHC grant, and subsidies on land, rent and staff secondment, as well as donor support in covering direct costs for delivering HIV/AIDS, malaria and TB services. However, the cost of medicines and health supplies are still high despite the advantageous prices offered through JMS. Additionally, PNFP labor costs are rising due to recruitment of qualified staff that require higher salaries in comparison to the MoH compensation packages. At the same time, PNFPs are experiencing declining revenues because overseas donations from member faith-based organizations are decreasing, the PHC grant is not sufficient to cover operating costs, and PEPFAR does not allow PNFP to charge administrative fees to manage the HIV/AIDS program (medical bureau interview). Increasingly therefore, PNFPs are forced to rely on user fees from a population group, similar to the one PHPs serve, who are not able to pay and this trajectory is not financial sustainable.

5.2. Market Asymmetry in Financing the Private Health Sector

5.2.1 Demand Side: Health Sector Financing Needs

A 2014 survey¹⁹ carried out by the USAID supported Private Health Sector Program found that Uganda's private health sector largely relies on its own savings (retained earnings) or informal borrowing to manage its operations (see Table 5.1). The same survey found that 78% of the healthcare facilities interviewed indicated that their major constraint to running operations was lack of financing, specifically to purchase new equipment and for working capital needs (51% of them were hospitals and clinics in addition to pharmacies, pharmaceutical manufacturers, medical equipment suppliers, and medical training facilities). However, the same survey found that only 16% of health businesses had borrowed from a bank for business purposes. Similarly, in an earlier study²⁰ (IFC, 2010) 8,000 health businesses were interviewed and of these, only eight (8) had access to financing through commercial banks, with loan amounts ranging from \$100,000-\$4,000,000 for three to five year terms, and paying annual interest rates between 16% - 20%.

Table 5.1: PHP Sector Sources of Financing

Types of Financing	Percentage
Retained Earnings	62%
Commercial Banks	16%
Friends of Family	12%
Supplier Credit	6%

Source: USAID/Uganda PHS, 2015

Uganda's private health sector requires additional funding to grow and meet the population's demand for health services. Based on one estimate made by an IFC/Deloitte study in 2010, there is a potential \$427 million financing gap for short and long-term borrowing from this sector making it a significant market opportunity for Uganda's commercial banks and microfinance institutions.

Table 5.2 breaks down financing needs by business type. In general, larger private hospitals and pharmaceutical manufacturers have accessed formal credit more often than smaller facilities or sole practitioners.

Table 5.2 Health Sector Demand for Financing

Category	Value of Financing (US \$ million)	Percentage of Total
Hospitals	358.0	84%
Clinics	30.0	7%
Laboratories	4.7	1.4%
Pharmacies and Pharmaceutical Distributors	6.0	5.5%
Medical Equipment Supplies	23.5	1.0%
Medical Education Facilities	4.3	100%

Source: IFC Market Studies: Uganda Report from 2010

Uganda's hospitals are driving the majority (84%) of demand for financing in the health sector as reflected in their percentage share of credit accessed, but smaller clinics often cannot obtain start-up financing.

¹⁹ USAID/Uganda Private Health Support Program, 2015. *Uganda's Private Health Sector: Opportunities for Growth*.

²⁰ International Finance Corporation, 2010. *Health in Africa Initiative Market Studies: Uganda Report*.

Despite this constraint, private clinics remain a significant opportunity for advancing credit from financial institutions given that they accessed only US \$ 30 million or 7% share among the study participants. The health sector’s financing needs are predicated on a steady and increasing demand for health services. In the 2014, USAID/PHS survey 90% claimed that demand for their services has been increasing in the past two years and they have explicit plans for expansion.²¹ These findings are summarized in Table 5.3. Specific areas of growth reported by those interviewed include:

- Expansion of general services (child health, dental services, maternity wards and delivery support)
- Increased specialization of services (cervical cancer screening, surgeries)
- Diversifying clientele (reaching a wider spectrum of clients, including middle class)
- Partnerships with other health clinics/hospitals (to serve as a local referral after surgeries, deliveries, or specialized treatments).

Table 5.3: Growth Plans for Expansion Projects in Private Clinics

Upgrade Project	Percentage of Projects	Loan Type
Purchase new equipment	82%	Medium-Term
Purchase new, diversified supplies (medicine)	15%	Short-Term
Diversify services	45%	Medium-Term
Expand space/construction	33%	Long-Term
Purchase land or construct new facility	32%	Long-Term
Hire and train new staff	15%	Medium-Term
Establish an accounting system	10%	Medium-Term
Enroll with private health insurance providers	6%	Medium-Term

Source: USAID/Uganda PHS Program, 2015

These efforts will all require additional funding in the form of short, medium and long-term financing from Uganda’s formal financial sector. The Program’s baseline survey of its cohort of 140 partner clinics indicated that 38% of those interviewed had recently invested in the growth of their business and an additional 32% had plans to borrow funds in the near future to support their health business’s growth. Health businesses also noted that they mostly managed their cash-based operations through a bank account and saved their profits in banks and savings institutions.²²

5.2.2 Supply Side: Financing the Health Sector

Based on data from Uganda’s Credit Bureau Compuscan, the financial sector gradually increased its lending to the private health sector from 2011-2013.²³ Since 2009, there have been 1,682 loans disbursed to 534 health sector businesses. The value of current loans outstanding to health sector businesses is UGX 22.4 billion (\$6,747,000) as of March 2015. This lending is driven mostly by commercial banks, representing 96% of loans disbursed and 98% of loan values to health sector businesses. While these numbers show a positive trend in health sector lending, the value of this lending represents only 1% of Uganda’s commercial bank total loan portfolios.²⁴

²¹ Uganda’s Private Health Sector: Opportunities for Growth. USAID/Uganda Private Health Support Program. 2015

²² Health Sector Borrowing in Uganda, Compuscan (Credit Bureau), 2015

²³ Ibid.

²⁴ Ibid.

There has been significant growth in lending to individuals for health purposes – which has doubled (in value) since 2009. In general, commercial banks disburse 78% of the value of all loans in the health sector to individuals. In the last 5 years, 613 loans were disbursed to individuals for health sector purposes; 50% of these borrowers were under the age of 35. An example of a typical loan is a doctor borrowing for the capital needs of his/her health facility. Values of loans given to individuals are much smaller than those given to health businesses, averaging UGX 425,000 (US \$180). Female individual borrowers between the ages of 31-40 comprise 50% of those borrowing for health businesses. The delinquency rate for individual health loans is slightly worse than that for health businesses, averaging between 5%-7%. The Compuscan Credit Bureau assessment of health sector loans between the years 2009 - 2013 indicated that they performed slightly worse than the banking sector's small and medium sized enterprise (SME) lending portfolio. In this period, the value of delinquent health loans was less than 5% compared to 2.8% - 4.1% for general SME borrowers. By way of contrast, Centenary bank health sector business borrowers' delinquency rates have averaged 3.5% from 2014 – 2016.

5.3. Uganda's Financial Sector

The financial sector in Uganda consists of the banking, microfinance, insurance, and investment sectors, as well as the Uganda Securities Exchange and the Capital Markets Authority, among other players. Generally, the sector is categorized into formal, semi-formal and informal institutions. The formal institutions supervised by the Bank of Uganda (BoU) include Commercial Banks, Credit Institutions, and Microfinance Deposit-taking Institutions (MDIs). Other formal institutions not supervised by BoU include insurance companies, development banks, pension funds and capital markets. The semi-formal institutions registered at the national level but not regulated by the BoU, include SACCOs and other microfinance institutions. The informal category combines all other community-based associations, including Village Savings and Loan Associations (VSLAs), Accumulated Savings and Credit Associations (ASCAs), and Rotating Savings and Credit Associations (ROSCAs).

5.3.1 The Banking Sector

The banking sector dominates the financial sector, with 25 commercial banks licensed as at March 2016 (BoU website). There was also relatively modest growth in bank branches - 68 to 564 over the last year (2015/16). Most of the banks are foreign-owned and include major international institutions such as Stanbic Bank, Citibank, Barclays, and Standard Chartered, which operate alongside a number of locally owned banks including DFCU Bank, Crane Bank and Centenary Rural Development Bank. Only a few of these Commercial Banks, Centenary Bank, have a traditional microfinance component. However, more banks are developing outreach mechanisms to tap into the microfinance market. For example, Barclays Bank and Postbank have developed products for linking VSLAs and other initiatives to deepen outreach including mobile banking. The Average Compounded Growth Rate (ACGR) in the industry's total assets and loan book, over the 2014-15 period, was relatively modest at 12.8% to UGX 19.6 billion and 9.8% to UGX 9.4 billion, respectively. This modest growth in spite of a stable economy can be attributed to the banks concentrating on improving the quality of their loan books after the lingering economic shocks from late 2011. Those banks that had stabilized still employ a cautious lending policy. The growth of mobile money use has also curtailed growth areas for banks.

According to the BoU Annual Supervision Report of 2014, a growing number of the unbanked population is shunning the traditional financial services, such as commercial banks, and relying on mobile money. Mobile money offers an efficient, cost effective, convenient and secure channel to make and receive payments, transfers and for cash safekeeping (e-wallet) and therefore provides a mechanism for bringing the unbanked population into the formal financial system.²⁵

²⁵ <https://www.bou.or.ug/bou/bou-downloads/asr/2014/Dec/Annual-Supervision-Report-2014-.pdf>

Based on key performance indicators, the banking sector is generally growing, profitable and adequately capitalized. By the end of 2012, banks' lending to the private sector as a share of gross domestic product (GDP) had risen to 15% up from 6% at the end of 2000, which is a five-fold rise over this twelve-year period.

According to the BoU, in 2012, the banking sector registered a strong growth and the capital adequacy ratio was 18.8% at the end of the year. The banking system is profitable, with an annual return on assets of around 4%. Banks have operated in a much improved and stable macro-economic environment. Inflation has stabilized and averaged 5% over the last 2 years, but even more significant, it steadily reduced and was 1.8% by December 2014. The economy continued to improve its growth rate, increasing from 4.2% in 2013 to 6.5% in 2014, thanks to an increase in both efficiency and volumes of tax collection, mainly invested in infrastructure (roads) development.

5.3.2 Microfinance Institutions

The microfinance sector is the most complex component of the financial sector. One provider of Microfinance services is in the category of Tier I, two are in Tier II and currently, there are four MDIs in Tier III. Additionally, SACCOs and unregulated MFIs serve the microfinance market. These institutions are broadly captured as Tier IV institutions.

MFIs contribute to the growth of the financial sector and the transformation of four (4) MFIs into MDIs enables them to offer more services to small-scale clients. Table 5.4 provides a summary of the current MDIs in Uganda supervised by the Bank of Uganda. By the end of 2012, the Microfinance Industry in Uganda served 1.3 million depositors and 553,000 borrowers.²⁶ Between 2011 and 2012, there was very limited growth or even stagnation in terms of the number of borrowers, which is an indicator of increased competition while demand stayed constant. The loan sizes of regulated institutions are still slightly larger than the loans disbursed by Tier IV financial institutions.

MFIs might be a lending option for small loans for healthcare providers such as nurses/midwives, and possibly for some pharmacists who may require small loans but lack collateral. MFIs stakeholders interviewed for the PSA expressed an interest in the health sector. However, they do not offer loans with long durations or large principal amounts. Although the MFIs offer individual loans, their focus is still on group lending. Most of the MFIs, for example, provide a range of loan products such as business, emergency, start-up, and individual loans, with durations of usually less than one year although some tenures extend to three years. Another drawback of MFIs is that their interest rates are even higher than those of commercial banks, reflecting the higher cost of underwriting many small loans.

Table 5.4: MDIs Branch Operations since 2004

Name of MDI	Year of Licensing	No. of Branches
FINCA Uganda Ltd (MDI)	2004	27
Pride Microfinance Ltd (MDI)	2005	30
Uganda Finance Trust Ltd (MDI)	2005	30
UGAFODE Microfinance Ltd (MDI)	2011	12

Source: Uganda Microfinance Directory, 2013/14. AMFIU, 2014

MFIs already have exposure to health sector lending although they do not tag these loans. The Association of Microfinance Institutions of Uganda (AMFIU) indicated that 58% MFIs give out loans for 'emergencies'.

²⁶ The State of Microfinance in Uganda: 2012/13. AMFIU, 2013

Emergency loans are usually used for health-related expenses and burials. Insurance services for microfinance clients are still underdeveloped in Uganda, but some institutions offer health care or catastrophe insurance schemes.

Several MFIs are also currently designing a micro leasing product, which would be of interest to small, rural health clinics. Most rural health clinics have limited equipment and are in dire need of funding to make this purchase. In Uganda, micro leasing is still a relatively new product and there is a high demand among most private health clinics for this type of financial product. Micro leasing can be an area for future donor resources and attention. In general, MFIs are interested in exploring how to lend to this sector and to gain a more thorough understanding of its characteristics.

5.4. Challenges Facing Financing Institutions in Uganda

Despite recent growth, financial institutions in Uganda are facing a number of challenges. Overall, inflationary pressures in the wider economy pose a threat to expanded lending to the private health sector. The Development Credit Authority (DCA) banks are operating in a tight macro-economic environment that has seen inflationary pressures on the cost of capital and the interest rates charged on loans. The Central Bank recently raised the base lending rate to 16%. These factors all mean that the cost of borrowing has gone up even for the targeted healthcare businesses. Banks are also facing other challenges, including increased pressure to invest in technology, declining interest margins, increasing competition, and the need to diversify.

The Banks interviewed for the third DCA assessment reported that they do not have statistics on health sector loans because health sector lending is not specifically tracked in bank loan portfolios²⁷. All of the financial institutions interviewed indicated that the health sector was not a significant sector in terms of lending compared to other booming sectors such as agriculture, energy and transport. Despite the limited levels of lending and lack of information on health sector lending, all of the financial institutions interviewed indicated interest in lending to the sector and were interested in USAID/PHS 2014 market research survey.

5.4.1 Perceived Risk

Many of the financial institutions interviewed for the third DCA Assessment identified risk as a significant constraint to lending to the health sector²⁴, reflecting a number of factors discussed earlier: the predominance of sole proprietorships, the fact that healthcare is viewed as a social good, and the unique regulatory considerations of health care. These risks can be mitigated by market information on healthcare businesses and credit scoring, as well as loan guarantees and facilities designed by donors to encourage lending.

Some of the risks identified by financial institutions in lending to healthcare businesses are risks that are generic to the SME sector. Until 2008, no licensed credit bureaus could systematically collect data on borrower's loan history. There are now two licensed credit bureaus in Uganda; Compuscan, which has been in operation since 2008, and Metropol Corporation (Kenya) Limited, a new entrant in late 2015. These credit reference bureaus are collecting performance data from the regulated institutions but the quality and usefulness of the data will remain limited until the new credit bureau system is fully operational.

Also associated with perceived risk of lending, SMEs often have no audited financial statements. As such, some banks will not lend to them or they will offer very high interest rates (to offset the perceived risk of lending).

²⁷ In 2014, the USAID/Uganda Private Health Sector carried out an assessment of 12 Tier I commercial banks to select a potential third bank to partner with USAID to offer health financing under a partial risk guarantee

In addition, health care businesses do not have the required collateral to meet the lending conditions of most banks, e.g., equal to one hundred percent (100%) or more. All commercial banks require audited financial statements from certified accountants for loans exceeding thresholds ranging from UGX 30 million to 50 million.

One notable exception is Ecobank, which requires audited statements from all loan applicants irrespective of loan size. In financial statements, However, cash flow may be understated (typically for tax reasons), which lessens the usefulness of the statements in assessing loan quality. Most of the banks surveyed typically validate the cash flow or financial statements by analyzing inflows and outflows from checking and savings accounts. Almost all of the banks require loan applicants to have had a checking or savings account with them for at least six months.

5.4.2 Collateral Conditions

Some form of collateral, usually a land title, secures the majority of SME loans. Lenders are concerned about securing collateral in the event of default; but in the case of health providers, lenders are reluctant to take the land or collateral of a clinic or hospital given the public relations problem of closing such a facility. Additional concerns are the accuracy and reliability of appraisals and confirmation of the lien position. For the banks interviewed, collateral requirements range from 100% to 200% of the loan amount, depending on whether it is immovable (personal house, building) or moveable property (vehicle, machinery).

Centenary Bank is an exception in that collateral requirements vary substantially depending on both the loan size and the risk classification of the applicant. It is the only bank accepting *bibanja* (a customary tenure of land ownership as collateral). Notable about this is that the land is not registered property. Even MFIs in Uganda often require substantial collateral for loans. Most of them require that loans be 100% collateralized, although the collateral is mostly composed of movable assets such as household appliances.

5.5. Constraints to Accessing Financing

5.5.1 Demand Side: Health Provider Perspective

Health care facilities face many of the same constraints in accessing financing, as do other small and medium-sized (SMEs) businesses in Uganda. This includes the following:

Private providers often lack financial statements, business plans, and business skills. Even health care providers that have active, sustainable practices often lack audited financial statements, business plans, or systems for analyzing costs or profit. Sole proprietors are often unable to say how profitable their practice is or what activities generate the most profit in their medical facility.

While providers may understand why banks need to have financial statements and a business plan to evaluate a loan application, they often lack the capacity to develop them. More generally, inability to analyze which of their activities is profitable can lead to misallocation of resources and missed opportunities for expansion.

With little rationalization of investments, justification and approval of loan proposals becomes difficult, hindering expansion of equipment or facilities. Although a provider may not be able to evaluate the profitability of an investment, many may bow to competitive pressure from clients and procure the latest diagnostic or treatment equipment. The pressure on private providers to over-invest in such services leads to underutilization of equipment and more inefficiency in the health system.

Resistance to applying business principles to health care. As large as the private commercial sector has become, many Ugandans believe that health care should be a public good, not a profit-making business.

This perception may influence consumers' unwillingness to pay for consultations that they do not consider treatment. As a result, write-offs of bad debts on cash-paying patients are substantial.

The notion that providing health care and managing a business effectively is incompatible also underlies the resistance of some providers to seek out business training in management, information technology, and insurance. It may also be a factor in the reluctance of medical schools to include management, ICT, and insurance courses in their curricula.

Cash flow constraints. In addition to bad debts from fee-for-service clients, revenue recovery for insured patients can be problematic, even though they typically make up a small portion of total clients. Corporate sponsors generally pay in 30 days, but some of the providers interviewed mentioned six-month delays in payment, resulting in providers having to spend time and resources in collections.

Lack of business and financial management skills. Health businesses also admit that while many plan to expand their practices, most recognize that they need additional training and technical assistance to turn these plans into reality. Types of training and assistance most often requested by health businesses include how to access financing, general business management skills, financial management and how to establish an accounting system, improving clinical quality of services, and registering with private health insurance providers.

On a positive note, many health clinics claim to access mentoring and counseling assistance. These include assistance from Ugandan-based franchises (e.g., Marie Stopes, PACE), the NDA, and various donors. One facility received support to participate in an exchange visit from Barclay's Bank and one paid an accounting firm to establish more formalized financial systems. Overall, technical assistance to Uganda's health sector has focused on improving the quality and availability of medical services and much less on the business and financial management skills the health businesses specifically identify as areas of weakness.

Loan products are not favorable. Many of the loan products and terms offered by financial institutions in Uganda do not meet the financing needs of private health sector businesses. For example, financial institutions largely lend to businesses against fixed assets as security. Acceptable security collateral requirements are even made more cumbersome by their limitation to only registered property, which is largely titled land. This is particularly challenging for female business owners because the land tenure system is still largely patriarchal with few women able to inherit land. Due to these challenges of borrowing as a business, health clinic owners often borrow as individuals requesting smaller and sometimes unsecured loans.

Although there are possibilities of lending against the cash flow of a business, financial institutions have adopted a very conservative attitude towards lending against projected earnings. Information availed to the PSA by the Uganda Bankers Association reveals that most commercial banks require collateralization of anywhere from 100% to 200% of the loan amount regardless of a business's cash flow. In addition to collateral, financial institutions require that SME business loans be appraised against their audited financial statements and that three years of audited statements accompany a loan application.

All commercial banks require audited financial statements from certified accountants for loans exceeding thresholds from UGX30 to 50 million. This is a big obstacle to health sector businesses seeking finance because most of them do not keep proper books of accounts and therefore cannot have audited statements.

Loan terms offered by banks also do not meet health business capabilities. Loan tenures typically do not exceed 48 months and there are no grace periods offered. In addition, bank requirements to commence loan repayments 30 days after loan disbursement places a huge strain on small business cash flows. As a result of these conditions, potentially viable health businesses do not seek out formal sector financing. Loan terms offered by banks also do not meet health sector requirements.

Interviews held with the Uganda Bankers Association revealed that among the five top tier banks in Uganda (Stanbic Bank, Centenary Bank, Barclays Bank, Standard Chartered Bank and Housing Finance Bank) the average loan amount to the SME sector is \$7,000 equivalent. This average loan size would meet the lending needs of many sole proprietor medical providers, ignoring larger medical facilities. Bank loans generally are more readily available to individuals who also have a salaried job (unsecured lending) with employer acting as guarantor for salary as the source of repayment for the loan. The average loan value for businesses across the country is UGX 46,620,000. Medium sized businesses have the largest average share of loans valued at UGX 288,290,000. Macro-sized businesses have loans averaging to US \$13,000,000.

Lack of start-up financing loans. Providers' greatest need for credit arises when starting a new practice. However, banks usually do not offer start-up loans, and doctors are reluctant to borrow because of uncertain ability to repay and extensive competition. The Program DCA borrowers' baseline study indicated that they were only able to start their businesses with personal savings and financial assistance from friends and family.

Start-up costs for the healthcare practitioners are substantial – the equivalent of tens of thousands of dollars for a pharmacy, nursing home, or clinic – and are especially high in the central region. Most physicians manage their own clinics and hospitals and nurses who own their businesses usually manage maternity homes. Most of the providers had expanded their practices over time and almost all of them did so without bank financing.

High interest rates and negative attitude towards banks. Healthcare businesses have a negative impression of the banking sector. Based on a 2013 survey of 91 health facilities, 37% had a negative or very negative attitude towards banks and/or borrowing, but an equal proportion had a positive attitude. Many health care businesses complain of the high interest rates and banks' lack of proactive outreach to the health care sector. The Program's 2014 survey of 32 DCA loan recipients noted that most of them (54%) reported their biggest challenge after receiving their health business loan was the high interest rates charged by Centenary Bank. Forty-seven percent (47%) complained of the inability to obtain long-term fixed asset financing. Although interest rates had decreased after the 2011 financial crisis, they are now going up again.

In 2016, the lowest commercial bank prime lending rate was 23%, plus a risk premium of between 3-10% depending on the bank.

Medical equipment financing. In many countries, leasing can be an important source of financing for private providers. Health care businesses worldwide use leases to acquire equipment. Leases can be a good option for providers who do not have access to lump sum funding. In many cases, a lease is structured so that the equipment being financed is the security, which can be beneficial for providers that do not have adequate collateral for other types of financing. Although banks in Uganda offer asset financing, they do not generally offer lease funding for medical equipment; industry suppliers offer lease financing only for certain lab equipment where the cost is recovered through reagent purchases, as well as for some oxygen generators. When medical suppliers do give credit, it is often only for a short duration (30 days) or for an amount that is too small to meet the financing need.

In addition, although using loans to purchase equipment may look to be a viable venture, clinics may not be fully prepared to maximize the utilization of this equipment i.e. they may not have planned for the technical training of in-house staff on using the equipment or hiring additional staff for this purpose. Without the ability at the health clinic level to fully utilize its medical equipment, the business loses the full benefit of equipment – both medically and financially.

Lack of long-term financing. Many health care providers in Uganda have difficulty in repaying loan tenures of less than one year, as their cash flow is not sufficient for shorter terms. This is particularly true for borrowing for medical equipment purchases and expansion/construction costs.

While longer financing of up to five (5) years is available from most commercial banks, it appears that many private providers are not able to access long-term loans and are forced to rely on short term loans (on average 48 months), which do not meet their broader financing needs. Most banks are most comfortable with providing health businesses, e.g., pharmacies or drug stores, with short-term (30-65 days) financing for working capital. Some pharmacists are able to secure up to 90-day financing for drugs supply purchases. The other business types such as clinics and maternity homes do not have as much access to credit for medical supplies as pharmacies, which can result in difficulty in finding everyday working capital.

5.5.2 Supply Side: Financial Sector Perspective

Despite the recent increase in interest by financial institutions in MSMEs, lending to the sector is still limited. In 2014, the Program carried out an assessment of twelve Tier I commercial banks to select a potential third bank to partner with USAID to offer health financing under a partial risk guarantee. This assessment found that although the bank had dedicated portfolios to this sector, none of the banks had incorporated an MSME strategy into their methodology for credit assessment or management of loans. According to the 2010 *Health in Africa Initiative Market Studies*, the main reasons banks do not lend to health facilities are:

- **Lack of business and financial management expertise.** The absence of business and financial management skills can result in the health businesses' poor management of funds, lack of financial records, and understanding the importance of basic documentation needed to acquire financing. For example, PHP owners' inability to document their business's profitability makes it difficult for financial institutions to assess their financial viability.
- **Lack of acceptable collateral security.** Health sector businesses often have limited sources of collateral given that the majority (61%) rent their premises and banks prefer not to accept equipment as a movable form of collateral as they feel they cannot sell equipment easily on the market in cases of default. Many health clinics do not have alternative security such as land. Institutions can be a real constraint for private providers in accessing financing. Many small and medium private health care providers operate out of rented facilities, or they are reluctant to pledge family homes as collateral for a loan. In addition, most commercial banks do not view medical equipment and other operating assets of health care providers as acceptable collateral.
- **Perceived limited demand.** Banks also perceive the health sector as having limited demand in terms of volume and loan size. Compared to other sectors, health businesses do tend to be smaller and these businesses have a limited absorptive capacity. For example, in the 2014 survey of 140 health clinics, 43% of them were earning a profit of approximately UGX 2 million (US \$830) a month, with another 25% earning up to UGX 6 million (US \$2,500) and about 11% earning up to UGX 20 million (US \$8,300) a month. This same survey did go on to note that 57% of clinics experienced increased profits in the past year indicating that while the health sector is growing and there are significant financing needs, individual loan sizes will be relatively small.

Take Home Messages on Private Sector Access to Health Financing

- **Market conditions are difficult for PHPs.** PHPs confront high input costs (e.g. land, power, VAT, and import tax). In addition, donor funds crowd PHPs out of certain markets such as FP services, TB and HIV/AIDS.
- Although PNFPs enjoy certain benefits, **PNFPs face the same difficult market conditions as PHPs.** Key constraints common to both PHPs and PNFPs include: i) high staff turn-over (constant movement between sectors), ii) competition from “quacks”, iii) barely covering costs because the majority of clients cannot afford to pay, iv) struggling to earn marginal profit (surplus for PNFPs) and v) no pricing guidelines to level playing field and protect consumers
- **PNFPs face financial uncertainty under current financing mechanisms.** The PHC grant woefully underfunds the cost to deliver the services they provide. And grant funds do not pay for the management services bureaux offer, which ensure quality and compliant services. PNFPs are increasingly reliant on user fees but they are still not sufficient to cover costs. Donor funds have provided some financial relief but they are restricted to certain services (e.g. HIV/AIDS, malaria and TB) and do not invest in building Bureau’s capacity as network manager of PNFP facilities
- **Many PHPs deliver key services to the poor but have limited access to government and/or donor benefits.** PHPs serving the poor are not exempt from taxes on medicines, equipment and VAT or are unaware of exemptions. Moreover, PHPs are not consistently included in donor funded training, subsidized inputs (e.g. drugs, test kits) and technical assistance.
- **Both PNFPs and PHPs need access to capital** so they can improve their facilities, purchase needed equipment and supplies, which ultimately produces benefits for the health sector.
- **Both PNFP and PHPs want to strengthen business and financial skills** so they can better manage costs, improve operations and become financially sustainable

5.6. Recommendations

5.6.1 Provide Business Advisory Support

Strengthen private providers’ business skills. Much focus is given to health care providers’ clinical skills and competencies. Nevertheless, in the private sector, many physicians, nurses, and pharmacists are also business owners who may lack the necessary skills to run a small company. As noted above, this lack of skills is a deterrent to the expansion of business services and coverage. One of the most critical ingredients to address the gap between health sector demand and commercial bank supply is the provision of business advisory services to the health sector to improve their financial acumen. Banks are often uncomfortable working with doctors who do not have much business management experience and cannot show loan officers the true profitability of their businesses. In general, there is poor financial management because of limited business management experience, financing record keeping, and oversight of the business’s cash/flow.

Doctors and clinic owners recognize this weakness and are very open to financial management training and support.

Box 5.1 USAID/Uganda Private Health Support Program’s Grants to Strengthen Business Skills

The USAID/Uganda Private Health Support Programme awarded grants to Makerere University College of Health Sciences and Private Sector Foundation to provide needs based Business Development Services to health care businesses, in particular clinics and hospitals, countrywide.

The first phase of the project ran for one year from October 2014 to September 2015. A significant percentage of participating private providers applied their newly acquired business skills including keeping records and tracking their income and expenses for the first time. This resulted in improved service utilization and client load numbers, introduction of new services, hiring of new staff and changes in physical environment thereby improving service quality.

The Program has taken steps to deal with this challenge by introducing the Health as a Business (HaaB) project, a business training and counseling aimed at strengthening the operations of the private healthcare sector for growth and sustainability.

The HaaB has to date supported a network of 209 private health clinics around the country with intensive business management training, accounting support and business mentoring. A mid-term survey conducted at the end of 2015 shows that the two hundred-nine (209) clinics that received training and business counseling under this program have registered an upward trend in revenue and stable-to-decreasing trend in operating expenses. Their mean monthly expenses have also decreased. Secondly, remarkable improvements in the caliber of health care human resources and health care equipment were noted, a positive development for the quality of care provided by the private health sector. Many participating clinics also undertook space expansion projects and introduced new services (including laboratory services, antiretroviral therapy, and dental services), a positive development for the availability of health services in the private sector (Box 5.1).

Improve private providers' knowledge about equipment access and use. Health businesses also noted that there is a significant need across the sector to better utilize newly purchased medical equipment. Although equipment suppliers usually provide a one-year warranty with free maintenance including technical training on the functionalities of the equipment and clinical training on the use of the equipment, Uganda's health businesses have found that securing qualified clinical technicians to use the equipment can be a significant challenge.

Larger sites – such as small hospitals – require more sophisticated support; for example, how to produce financial data to enable strategic level decision-making. For the smaller clinics, some of it is as basic as assisting them in applying for a loan which requires direct interaction with the banks, credit staff and finance managers as well as direct support to clinic staff to understand what their financing needs are (for example, Do they want to purchase a new or used X-ray machine? How will it be sourced and what will be the collateral?

In addition to some internal financial issues (like Do they understand their own cash flow? Can they successfully repay a loan? How do they obtain supplies – through supplier credit or other, should they have an accounting system?). In summary, technical assistance to the health sector could include

- Identifying financing plans
- Assisting to set up financial record keeping systems
- Making projected cash flows (for the loan period)
- Assisting in the creation of business plans
- Providing technical assistance to health lending bank branch staff on how best to leverage the guarantee instruments to meet the unique needs of potential health borrowers
- Offering technical assistance to distressed borrowers. This could include assistance to help them adjust their cash flows to meet the repayment terms or rescheduling of the loan repayment terms.

5.6.2 Increase Access to Affordable Finance

The 2010 IFC study provided insight on the need for short, medium, and long-term financing requirements of Uganda's health sector. This study noted a potential US \$427 million financing gap for short and long-term borrowing from the health sector making it a significant potential market segment for Uganda's commercial banks. While a large portion on this demand is from hospitals (84%), a projected US \$30 million is needed by Uganda's private health clinics to meet their growth and expansion goals. However, there is a mismatch between what health providers want (e.g. longer term, larger loans for construction and equipment) with what their revenue can support.

Surveys indicated that health clinics in particular have fairly small profit margins and need loans with smaller installments spread out over a longer period. Medium and long-term financing to support health business start-up is needed desperately to support expansions into areas of Uganda currently not served by existing facilities or to launch operations in less competitive markets, e.g., rural areas. In general, banks could expand lending to this sector by offering the following types of financing at flexible terms and reasonable collateral conditions:

- Long-term fixed asset loans to purchase new medical equipment
- Long-term (10 years +) to purchase land and renovate facilities
- Short-term working capital loans to purchase supplies
- Medium-term loans to recruit and train staff with new skill sets
- Staggered lending for business start-ups

5.6.3 Offer Technical Assistance to Health Lenders and Business Borrowers

Increase lenders and business borrowers' knowledge of the health care sector. Business advisory support to healthcare businesses must be coupled with assistance to the formal financial sector to increase their knowledge of this sector and decrease their perceived risk of lending to these businesses. Providing targeted technical assistance to banks expressing an interest in the health sector can be an important strategy to furthering capital flows to these businesses. This can include:

- Providing assistance in market analysis of the health sector to disaggregate demand by location, business type and loan sizes
- Assisting financial institutions to develop a strategy for targeting the health sector
- Offering tailored technical assistance to formal financial institutions to align their corporate interests with lending to the health sector
- Providing training for line workers (marketers, loan officers) on health sector characteristics, how to market and offer products that will address the sector's needs.

Expand access to micro leasing. Given that lack of equipment is a major constraint for most health businesses, expanding opportunities for equipment lending is needed. Donors could identify 1-2 MFIs already exploring the viability of launching a micro-leasing mechanism and provide technical assistance and training to further these efforts.

Box 5.2 Loans Benefit the Health Sector

The USAID-funded Private Health Support Program in Uganda works with Centenary Bank to offer loans to private health providers. A nurse in the Kabwohe Clinical Research Center in South Western Uganda received a \$35,000 loan.



With this loan, she was able to hire more staff, which increased the center's capacity to treat 4,600 more AIDS patients.

(Source: USAID/Uganda PHS Bi-annual Report, 2015).

Box 5.3 USAID/Uganda PHS Technical Assistance to Centenary and Ecobank

The USAID/PHS has offered multiple levels of assistance to its two DCA banks. At the highest levels, this included broad understanding of current market opportunities of lending to the health sector. The project has undertaken multiple market assessment studies to ascertain details regarding specific challenges and constraints within the health sector market, which have enabled the two DCA participating banks to more securely lend to the health businesses. Support has also included direct training to loan officers regarding health sector lending – and in particular lending to female-owned businesses. In addition, the Program has assisted the banks to identify qualified health businesses for lending, including rural and first time health clinics.

Offer credit guarantees. Credit guarantees can be part of a solution to expand lending to the health sector. Donors have developed guarantee mechanisms partially to offset the risk of lending to the health sector in Uganda. For example, USAID and SIDA are co-supporting US \$2 million, respectively. Centenary Bank has to date utilized 65.4% of its total guarantee amounting to US \$1,962,353. Ecobank has utilized 7.2% of its limit amounting to US \$50,980. This guarantee is a requisite part of the scenario to support and expand lending to the

private health care sector. The USAID/Uganda PHS Bi-annual Review 2015 of the USAID/SIDA health guarantees noted that dedicated technical assistance for monitoring, reporting and utilization for the participating DCA guarantee banks (Centenary and Ecobank) has been critical. While Centenary has a long history, and is the most experienced bank in using the DCA in Uganda, it indicated that the support in both training their staff and potential clients by the USAID/PHS has been invaluable to achieving strong utilization levels (Box 5.4). This training support has been further buoyed by the project providing a pipeline of clients from which the bank could choose clients to lend.

Box 5.4 Quality of USAID Health DCA Portfolio at Centenary and Ecobank

The quality of the USAID Health DCA portfolio at Centenary and Ecobank is strong. There have been only two notices of default made so far in the program, but all recoveries of arrears have been made and the bank has therefore not had to resort to making a claim against the guarantee to date. Total disbursements have included 47 loans worth (\$816,225.5) amounting to 27% of the total guarantee amount.

Provide technical assistance in increasing banks' skills to lend to the health sector. Technical assistance to the formal financial sector is an important ingredient coupled with support to the healthcare businesses. This includes assistance to understand the market better, loan officer training, strategy development, and pricing support. For example, commercial bank loan officers need better training on how to assess health businesses in terms of their cash/flow and viability. These skills will assist banks to understand the risks associated with lending to the health sector better, such as low turnover and possible delinquency. Developing loan products more tailored for the health sector will also require an improved understanding by the banking industry of the healthcare market.

As such, resources must be made to more fully understand and disaggregate this sector's financial needs vis-à-vis its financial capacity to absorb funding to grow.

Reform collateral requirements. Issues around collateral also need to be evaluated and creative solutions derived for clinic owners who lack ownership of land or property. In Uganda, banks uniformly require significant collateral for all loans – even those supported through a guarantee. One example offered by an innovative African commercial bank is the development of a series of graduated loans to enable expanded lending to female entrepreneurs. In this case, the bank offered female borrowers 'entry level' loans to purchase land that could later be used as collateral. Once those initial loans were repaid, clients were offered larger, longer-term loans for construction and equipment purchase. This graduated approach to serving female entrepreneurs could also work to address some of the constraints faced with expanding financing to Uganda's health sector, which often lack basic collateral required for borrowing.

Leverage the private sector. Develop partnerships with medical equipment suppliers, like Philips/Uganda, to develop co-guarantee arrangements as well as standardized maintenance contracts. These partnerships could address bank concerns of using equipment as collateral and the issue of (who will re-purchase used equipment) along with building the health sector's ability to use the full capacity of new equipment. Interviews for this report conclude that many financial institutions are interested in accessing advisory services to assist them to better understand and assess the viability of lending to the healthcare industry as well as develop products specifically geared for the sector. This is an important next step for donors and others interested in supporting Uganda's health sector growth.

6. PUBLIC-PRIVATE MIX IN HEALTH SERVICE DELIVERY

A review of the policy research on OECD health systems shows that governance structures and regulatory frameworks are different in each sub-sector, allowing for greater market forces or more government structure to shape a health market (Harding, 2015). When a government opens up to more private sector participation, many PNFPs and PFPs health care providers quickly enter into and dominate these health markets. Many aspects of the medicine supply chain and PHC for example, are delivered almost exclusively by the private sector in OECD countries, while in sub-sectors that are heavily regulated it is more difficult for private providers to enter and stay in these markets for example in most OECD countries, governments restrict hospital ownership to public and/or PNFP only.

Box 6.1 Definition of Health Market

A set of arrangements by which buyers and sellers are in contact to exchange goods or services in health; the interaction of demand and supply for a health service or product.

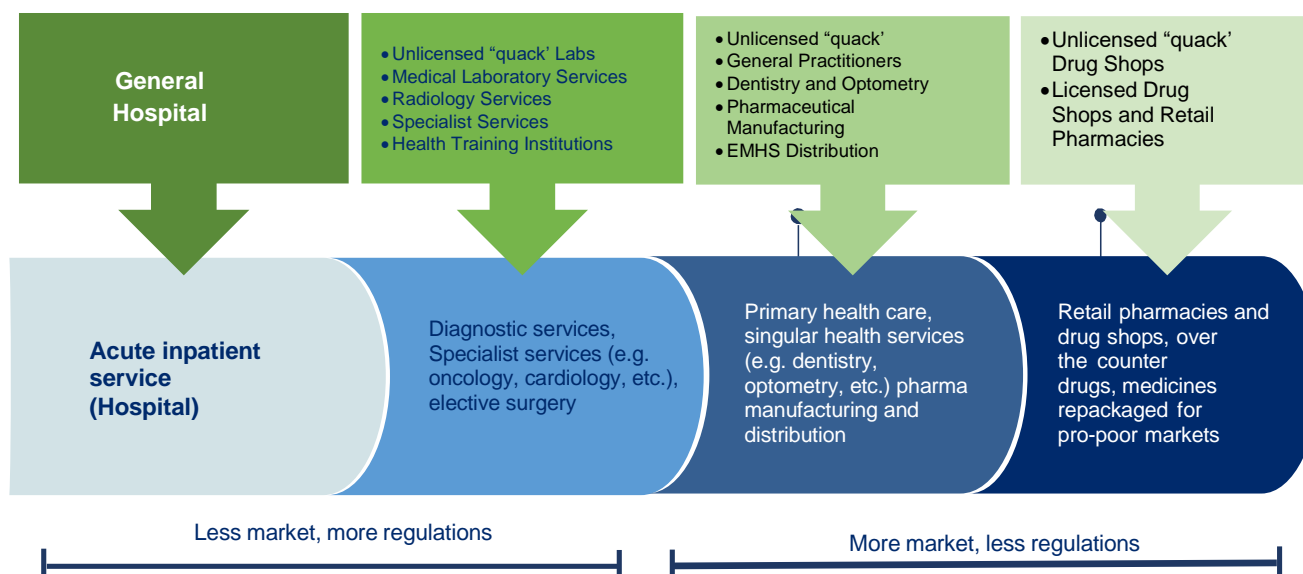
Yet policymakers, development partners and international experts often treat all health sub-sectors the same way and do not recognize that the private sector will play a larger role in certain sub-sectors while the government in others. This section examines the public-private mix by a select number of sub-sectors or health markets to understand why the private sector is more or less active in different health areas. Understanding the market dynamics is critical to formulating appropriate policies and strategies that can harness private sector when needed to deliver more PHC. An example is providing incentives such as subsidized contracts for PNFP and public yet the private sector bears a higher proportion of costs) or crowd them out when providers do not comply with minimum regulations to ensure patient safety (e.g. close down unlicensed facilities). This section will examine the public-private mix in three key health markets: HIV/AIDS, maternal and reproductive health.

6.1. Public-Private Mix in Different Health Markets

A review of OECD country health systems exhibits certain patterns of public-private mix in health sub-sectors (Harding, 2015). Certain health activities tend to be governed in ways that permit more market forces while others are consistently governed in ways that strongly limit or remove market forces (see Figure 6.1). Drug shops and retail pharmacies, over the counter (OTC) drugs and health products are subject to moderately strong market forces – customer competition, price, and entry barrier compared to other health markets such as acute inpatient care in hospitals, that is highly regulated by the government. Certain conditions or market system dynamics determine whether a health market is influenced more by markets or shaped by government policy. These dynamics include operational autonomy, customer competition, price influence, entry barriers, social funding and performance tension.

Synthesizing the Uganda data on private facility levels, HRH professions, site visits and stakeholder interviews, one can see the markets in which the private sector operates. As Figure 6.1 shows, the Uganda private health sector is concentrated in the sub-sectors that are more market driven, such as retail pharmacies, distribution and PHC. Although there is some private sector presence in the more structured markets, such as diagnostics and hospital care, it is in much smaller numbers. Unlike OECD and middle-income countries, Uganda lacks the governance structure to manage a mixed health delivery system and as a result, still has a largely unregulated private sector with ‘quack’ labs, drug shops and health providers that operate outside set rules.

Figure 6.1 Private Sector Activities by Health Market



Source: Adapted from Harding, 2012

6.2. Private Sector Contribution to HIV/AIDS Services

6.2.1 Background on the Epidemic

Historically Uganda is a leader in the region for presenting a unified, proactive response to curbing HIV/AIDS since the inception of the pandemic. The response has featured open communication, grassroots behavioural change efforts, and commitment at the highest political levels to coordinate and engage with all HIV/AIDS stakeholders. The country was the first in Africa to open a voluntary HIV testing center. In recognition to the early efforts, Uganda saw a reduction of HIV prevalence from an estimated 18% in the early 1990s (UAC, 2015) to an estimated 6.4% in 2005.

Alarming, in 2011 the prevalence rate increased to 7.3% (UAC, 2015²⁸). The country's last AIDS indicator survey, conducted in 2011, showed marked regional variations in prevalence, from 4.1% in the Mid-Eastern region to 10.6% in the Central region. In West Nile, HIV prevalence more than doubled (2.3% to 4.9%). Significantly for the private sector, which is more present in urban areas continues to have higher prevalence rates than rural areas. Recent studies show that prevalence is higher than the national average among key populations (sex workers, fishing communities, men who have sex with men, truckers, and members of uniformed forces) estimated between 15-40% depending on the key population (AIS, 2011). Uganda continues to experience an increasingly high burden of people living with HIV, with 1.5 million people living with HIV in 2014 (UAC, 2015). An AIDS Indicator Survey is planned for 2015/16, which is expected to provide updated and detailed data on current prevalence rates.

In response to the epidemic's resurgence, the government intensified the HIV/AIDS response, aggressively scaling up HIV prevention, treatment and care services.

Due to the significant scale up of treatment, Uganda reached the programmatic tipping point in 2013 and 2014 - defined as fewer new infections (approximately 140,000) than the net increase in adult patients on treatment (approximately 160,000). This indicates that the aggressive efforts by both the government and donors are showing promise, though Uganda continues to be classified as a high burden country (MoH, 2015).

²⁸ Uganda HIV/AIDS Country Report 2014. UAC, 2015

6.2.2 Private Sector in HIV/AIDS at the Policy Level

At the central level, two bodies coordinate the HIV/AIDS response in the health sector: the MoH (STD/AIDS Control Program) and the UAC. The AIDS Control Program (ACP) is responsible for overseeing the implementation of the HIV/AIDS response from a public health perspective, including behavioral (Abstinence, Be-Faithful and Condom Use [ABC] prevention) and biomedical interventions (HIV Counseling and Testing [HCT], Safe Male Circumcision [SMC], prevention of mother-to-child transmission [PMTCT], anti-retroviral therapy [ART] and opportunistic infection treatment). Established in 1992 under the Office of the President, UAC is mandated to plan and coordinate a multi-sectoral response, including overall coordination, mobilization of resources, policy development, and strategic development and dissemination of information.

Both ACP and UAC are perceived by respondents to be more supportive and inclusive of the private health sector than other health service actors. The MoH ACP employs a private sector focal person while UAC, through the HIV Partnership Mechanism established in 1992, engages a private sector group through the Partnership Committee, currently chaired by the Federation of Ugandan Employers (FUE). The Partnership Mechanism includes a Partnership Fund to support planning, monitoring and coordination functions of the Committee. However, key informants reported that the Partnership Fund does not have sufficient resources to support planned activities.

The UAC recently released updated HIV policies and plans for the 2015/16-2019/20 period: The National HIV and AIDS Strategic Plan (NSP) 2015/16-2019/20; the National HIV and AIDS Monitoring and Evaluation Plan 2015/16-2019/20; the National HIV and AIDS Indicator Handbook 2015/16-2019/20; and the National HIV and AIDS Priority Action Plan 2015/16-2019/20. Other key resources include the Uganda HIV Investment Case 2015-2025 (2014) and the Uganda National AIDS Spending Assessment (NASA) 2008/09-2009/10 (drafted in 2012).

Box 6.2 HIV Investment Case

The HIV Investment Case 2015-2025 recommends increased engagement with the private sector in support of Uganda's ambitious HIV/AIDS response in order to help increase access to HIV care, mitigate stock outs of HIV drugs and supplies, and bridge human resource shortages in the public sector.

The new NSP, the overarching document guiding HIV/AIDS policy and programming in Uganda, focuses on four thematic areas: (i) prevention, (ii) care and treatment, (iii) social support and protection, and (iv) systems strengthening. Targets, in summary, include reduction of adult HIV infections by 70% and pediatric infections by 95%; decrease of HIV-associated deaths by 70% through 90% viral suppression; reduction of vulnerability to HIV/AIDS for key populations and PLHIV; and universal access to quality, efficient and safe services.

The HIV Investment Case 2015-2015 (UAC, 2014)²⁹ projects that Uganda's GDP would increase at an annual average of 6.5% if AIDS did not exist altogether; but that growth in an "AIDS-without-ART" scenario would reduce to 5.3% annually and by 2025 the economy would shrink by 39%.

Through a modelling exercise, the Investment Case recommends a "feasible maximum" scenario whereby interventions are aggressively scaled up for three years to mid-term coverage targets of 80% for ART, 50% for HCT, 75% for condom use, 80% for SMC, and 95% for PMTCT. This would result in a 77% reduction in new infections, 58% reduction in AIDS deaths, and increased PMTCT coverage from 70% to 95%.

A total of US \$8.7 billion will be required during the period, and this would result in a projected funding gap of US \$250 million annually between 2020 and 2025. NSP goals are nearly aligned with this feasible maximum scenario, with reduced coverage targets for condom and SMC coverage.

²⁹ UAC, 2014. A Case for more Strategic and Increased Investment in HIV/AIDS Programmes for Uganda, 2015-2025.

Notably, the investment case identifies improved regulation and coordination for the private sector as a remaining challenge. Recommendations include strengthening policy and regulatory mechanisms, engagement through contracting out, franchising and social marketing, and increased promotion of private sector participation “to increase access to care, reduce stock outs of drugs and supplies and mitigate inadequate human resource gaps” (HIV Investment Case 2015-2025, 2014).

The 2012 NASA reveals that in 2009/10 public sources of funds contributed just 10.3% of overall HIV/AIDS spending while external sources (primarily bilateral donors) contributed 67.3%. Twenty two percent (22.4%) came from private sources – of which 21.7% is estimated to be from household OOP payments. Further, the analysis shows that the private sector (including NGOs, CBOs, and FBOs as well as PNFP facilities) supplies the lion’s share of HIV/AIDS services – an estimated 68.5%. Among the private providers, PNFP facilities supply the largest share of HIV/AIDS services at 78.9% and almost all these funds are used for care and treatment. However, one of NASA’s limitations of importance to the context of this private sector assessment is that the majority of private facilities sampled for the study were from the PNFP subsector. The assessment states that despite lengthy discussions amongst study stakeholders, data collection in the PHP subsector was limited to “a few” facilities in Kampala due to lack of data and perceived PHP sensitivity of sharing financial information (UAC, NASA, 2012). In addition, only one NASA has been conducted in the country due to the approach used, which was too costly. Key informants interviewed reported that UAC is in the process of negotiating with the Makerere University School of Public Health (MAKSPH) to conduct future NASAs.

“The private sector is playing a big role – maybe more than is usually appreciated.”
(UAC, NASA, 2012)

Predictions for global funding trends for health expect donor resources to level off for HIV/AIDS in the near future, particularly from PEPFAR, the largest source of funding for HIV/AIDS in Uganda. Uganda has already been experiencing significant fluctuations in donor pledges in recent years. Ireland, Norway, Denmark and the UK suspended funding to Uganda over allegations of corruption in 2012, and in 2014, the possible passage of the Anti-Homosexuality Act prompted donors to threaten to curtail or pull out funding altogether.

Further, under new leadership, PEPFAR has entered a third phase focused on sustainable control of the epidemic supported by data-driven approaches. This has resulted in a game-changing pivot in resources and programming in order to aggressively scale up treatment and reach ambitious ART coverage targets in all PEPFAR-supported countries. In Uganda, this will translate to a regionalization of the USAID and CDC program portfolios using ART coverage as the driving priority, with CDC overseeing the Central region, Rwenzori Region, Mid-West Region and West Nile Region while USAID will oversee South Western, Eastern and Northern Regions.

More than 400 sites serving low volumes of ART patients are expected to fully transition off from USAID support in 2016. In this new PEPFAR environment, reporting and monitoring of HIV/AIDS data will be key.

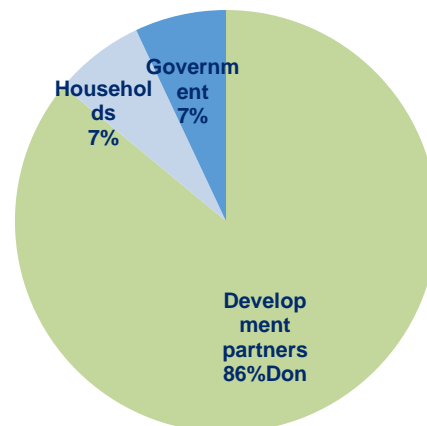
The HIV Investment Case proposes a few potential sources of domestic resource mobilization for HIV/AIDS:

- The NHIS, from which 30-35% of the program (approximately \$24 million annually) could be directed to HIV/AIDS;
- Oil/mineral revenues, of which 0.8% of the proceeds (approximately \$24.5 million annually) could be directed to HIV/AIDS;
- A social investment exchange, modeled after initiatives in South Africa and Kenya: could account for fifty percent (50%) of the required amount to bridge the gap for the feasible maximum scenario; and

- The AIDS Trust Fund, projected to provide \$100-\$250 million annually for HIV/AIDS service provision.

The initiative to establish an AIDS Trust Fund began in 2011 with a view to eventually resourcing Uganda’s entire HIV/AIDS response. Its establishment was approved by Parliament under the controversial 2014 HIV and AIDS Prevention and Control Act. Draft regulations for the Fund are currently under review in Parliament, and largely discuss powers and the organization of the board and fund managers. No specific details on the mechanics of service provision under the Fund have been developed, though the private sector is mentioned in the draft regulations as a potential recipient of funds for HCT and ART. The sole source of funding that agreed to date is a 2% of the total tax revenue collected from levies on beers, spirits or waragi, soft drinks and bottled water. However, when examining resources needed for the AIDS Trust Fund, there was a miscalculation of how much funding this 2% tax would raise. In reality, this equates to just \$2 million annually, which is vastly insufficient for what is required to operate this fund effectively.

Figure 6.2 HIV/AIDS Health Expenditure by Source



Source: 2011/2012 NHA Table 8.6

6.2.3 Financing of HIV/AIDS Services

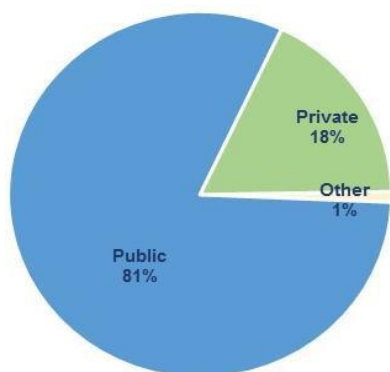
HIV/AIDS receives more funds than any other disease entity – more than 37.5% of health expenditure (NHA, 2011/12). The total amount expended in HIV/AIDS in 2011/12 was UGX 1,783,004 billion. As the 2011/12 NHA report notes, the spending pattern does not necessarily follow the disease burden. Figure 6.2 illustrates that development partners fund upwards of 86% of all expenditures on HIV/AIDS. The principal development partner is USG through PEPFAR. Such heavy reliance on one donor to fund the national response would have serious implications, if USG support to GoU were significantly reduced in any way.

6.2.4 Public-Private Mix of HIV/AIDS Services

There are two primary data sources for assessing the public-private mix of HIV/AIDS services: the Uganda DHIS 2 and UDHS 2011. The following analyses draw from both data sources unless indicated otherwise. As the data reveals, government, PNFP and NGO providers dominate the HIV/AIDS sub-sector. This is because PEPFAR funds focus almost exclusively on these types of providers. However, the PHP sector is underutilized and could be harnessed, as other SSA countries have done (see Box 6.6), to decongest crowded MoH and PNFP facilities and to offer ARVs to users at alternative locations where they can be treated with the confidentiality and privacy they need.

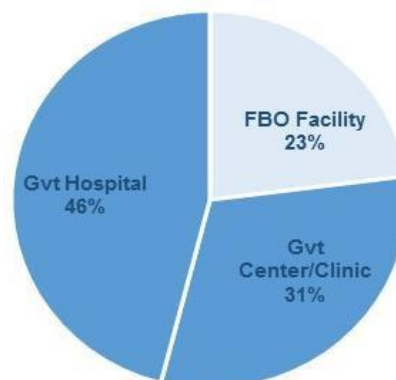
Source of HIV Test. The UDHS provides a wealth of information on where individuals obtain their last HIV test. Unfortunately, the UDHS did not distinguish between PNFP and PFP providers. Figure 6.3 shows that the majority of women (81%) got their last HIV test in a public facility while 18% tested in a private facility (PNFP or PFP). Of the public facilities, 46% of HIV tests occurred in a hospital and another 31% in a health center. The remaining 23% were in a FBO health facility (see Figure 6.4).

Figure 6.3 Source of Last HIV Test for women 15-49 years



Source: Secondary Analysis, UDHS, 2011

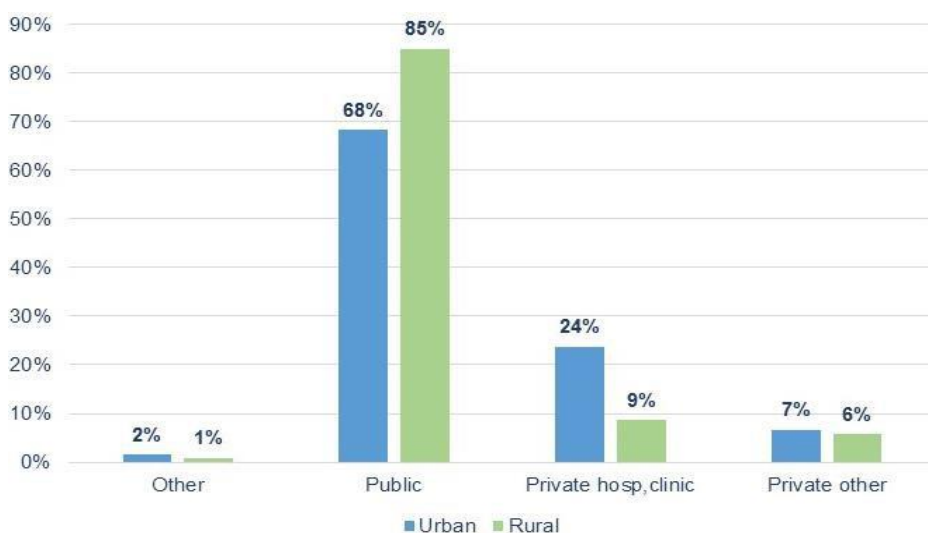
Figure 6.4 Public-Private Mix of Last HIV Test by Facility



Source: DHIS 2 2015

Of those tested in urban areas, 68% received their test in a public facility while 24% tested in a private (mostly PNFP) hospital and 7% in a stand-alone VCT outlet, drug shop, private physician or TASO/NGO facility (see Figure 6.5). In rural areas, more HIV testing took place in public facilities (85%) compared to private ones (15%).

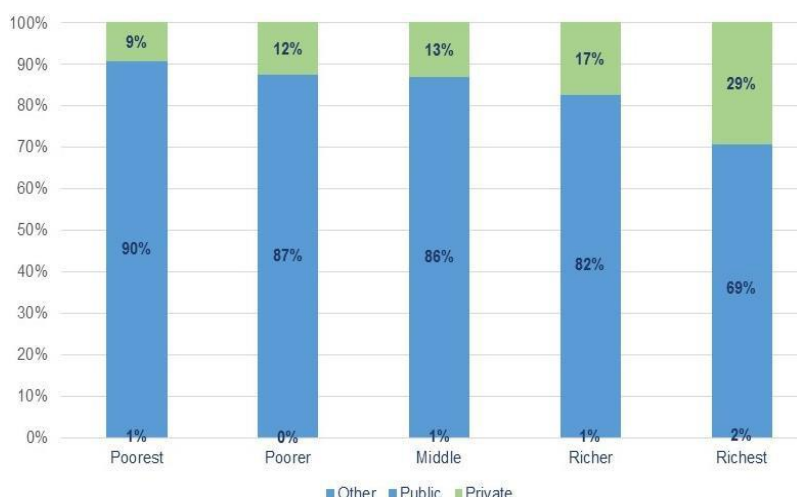
Figure 6.5 Location of Last HIV Test by Provider



Source: UDHS 2011 Secondary Analysis

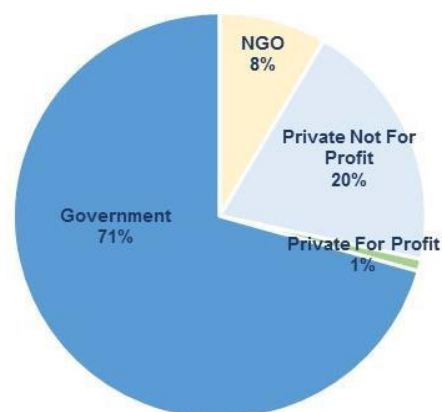
Figure 6.6 shows the source of one's last HIV test by income group. A public sector facility is the dominant source of the last HIV test across all income levels. As incomes rise, higher income groups were more likely to test in a private – mostly PNFP – facility – the ratio of testing at private: public facility rises from 1:10 in the poorest quintile to 1: 2.4 in the richest. Given the public health priority to decrease the rate of HIV/AIDS transmission, it is appropriate that government considers subsidizing higher income groups as an incentive to encourage all Ugandans to be tested.

Figure 6.6 Source of Last HIV Test by Income Group



Source: UDHS 2011

Figure 6.7 Public-Private Mix of ART Providers for Active Users



Source: DHIS 2, Jan-Dec 2015

Source of ARVs. The DHIS 2 tracks the number of active ART users and from where they obtain treatment. Among women and men aged 15-49 who report that they are currently taking ARVs daily, almost three-quarters (71%) obtained their medicines from a public sector facility - either a government hospital or health center (Figure 6.8). Almost one-third (29%) received treatment from a private provider, such as facilities affiliated with a religious organization (20%), an NGO (8%), or a PFP health facility (1%). Table 6.1 shows where individuals on ART get their ARVs by the type and level of private facilities ranging from Clinics, HC II to General Hospitals. According to DHIS 2 data for 2015, there are more than ½ million active users of ARVs served by the private sector. Most active users of ARVs get their supplies from private clinics or hospitals (26%).

Table 6.1: Number of ARV Active Users by Private Source of ARVs

Private Sector Sources	Clinics	HC II	HC III	HC IV	General Hospital	Total
Private-for-profit	6,449	5,925	2,782	373	1,983	17,512
Private-not-for-profit	82,842	40,470	60,670	14,190	163,671	361,843
NGO	130,211	18,535	3,294	0	685	152,725
Sub-total (%)	219,502 (43%)	64,930 (11%)	66,746 (18%)	14,563 (2%)	166,339 (26%)	532,080 (100%)

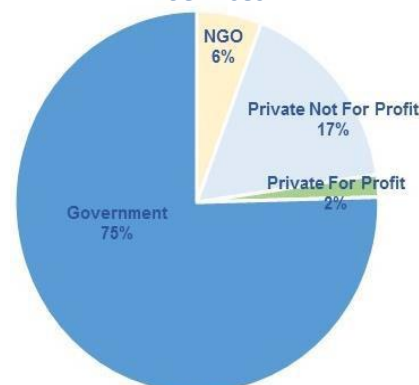
Source: DHIS2, Jan-Dec 2015

Safe Male Circumcision (SMC). The DHIS2 also monitors the number of SMCs performed and their providers. As Figure 6.8 shows, three quarters (75%) of all SMCs are performed in a public facility and one quarter (25%) in a private sector facility. Of those performed in a private facility, the largest proportion of SMCs is performed in a FBO facility (17%), followed by a NGO health facility (6%). Only 2% are performed in a PFP facility.

Table 6.2 provides the absolute number of SMCs performed in 2015 and the type of private facilities they were performed.

There were over 66,000 SMCs performed between January to December 2015 in private facilities. Most SMCs are performed

Figure 6.8 Public-Private Mix, SMC Services



Source: DHIS 2, 2015

at lower level facilities (HC III and below) in the private sector, although a substantial number are performed at PNFP general hospitals (37% of all PNFP SMCs).

Table 6.2: Number of SMC Performed by Private Provider and Facility Type

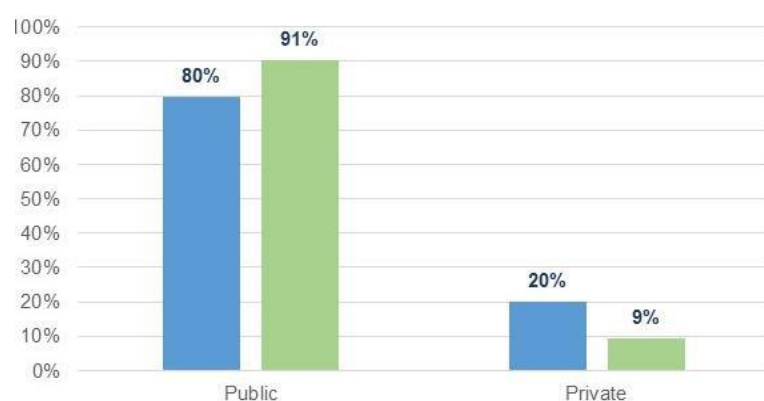
Source of SMC	Clinics	HC II	HC III	HC IV	General Hospital	Total
Private-for-profit	1,171	3,239	134	15	646	5,205
Private-not-for-profit	14,050	1,799	11,548	1,543	16,679	45,619
NGO	13,729	1,944	0	0	7	15,680
Sub-total (%)	28,950 (44%)	6,982 (10%)	11,682 (18%)	1,558 (2%)	17,332 (26%)	66,504 (100%)

Source: DHIS 2, Jan-Dec 2015

PMTCT. The UDHS 2011 was the PSA’s main source of data for PMTCT. Most (89%) PMTCT services are delivered in public facilities compared private ones (11%) (see Figure 6.9).

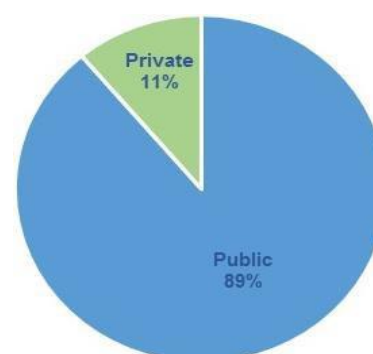
As Figure 6.10 demonstrates, of all the urban facilities offering PMTCT, 80% are public and 20% are private (both PNFP and PHPs). In rural areas, 91% of facilities offering PMTCT services are public health facilities.

Figure 6.10 Location of PMTCT Services by Provider



Source: UDHS 2011

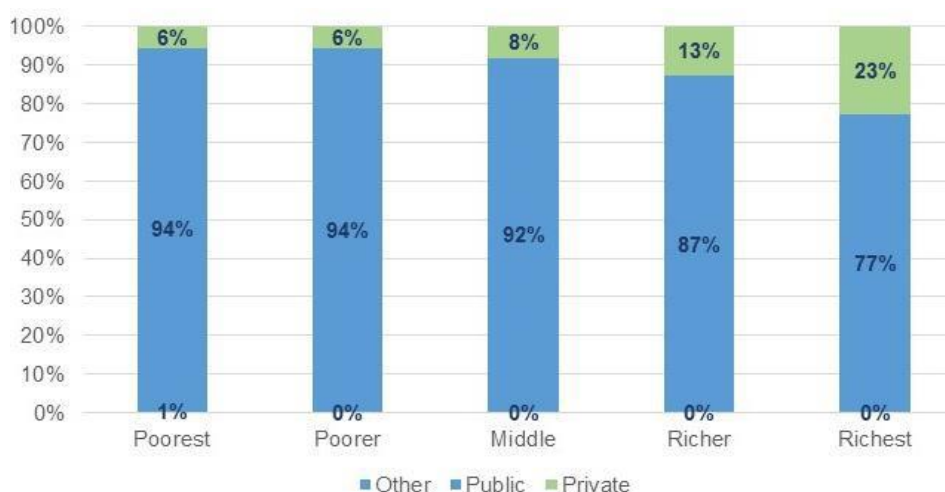
Figure 6.9 Public-Private Mix PMTCT Service Providers



Source: UDHS 2011

Figure 6.11 shows the source of PMTCT services by income group using a proxy indicator in the UDHS – number of pregnant women tested for HIV at first ANC visit. A public facility is the dominant source of PMTCT services across all income levels. Similar to HIV testing, as incomes rise, the higher income groups seek HIV tests in a private – mostly PNFP – facility. This is similarly a potential area for expanding PFPs’ role in helping decongest public maternity wards. In Tanzania for example, a network of private midwives (under their umbrella organization, PRINMAT) has expanded PMTCT services not only in urban areas but also in areas where there is limited public facility reach.

Figure 6.11 Source of PMTC by Income Quintile



Source: UDHS 2011

6.2.5 Discussion of PHPs Role in HIV/AIDS Services

Uganda’s system of decentralized service delivery features a unique program of accrediting private sector facilities, including PHPs, to provide ART using government-sourced ARVs and HCT kits provided at no cost to the provider. By leveraging the private sector, this has been a successful approach of extending and scaling up the delivery of priority services, as reflected in the recent AIDS spending data (NASA, 2012).

After successfully assessment against MoH-set standards in areas including personnel, drug dispensing, storage facilities, laboratory capacity, data management and linkages to community support mechanisms, facilities are accredited to provide ART (AIDSTAR, 2009). Notification of accreditation is in the form of a letter from the MoH. For the private sector, these drugs are provided through Joint Medical Stores (JMS) and Medical Access.

In terms of quality assurance of ART delivery, the MoH aims to assess the facility against standards regularly throughout the year, though in practice this is reported to rarely occur due to lack of resources. Once a year, the MoH also aims to conduct a “clean up exercise” to identify inactive sites and if necessary, remove their accreditation status. Donor funded programs support quality improvement of ART services at supported sites, along with other services (Box 6.3).

Respondents in the MoH reported that the great majority of PHPs have accessed this program, estimating an approximate figure of 80% of all facilities, although one PHP had abandoned accreditation, as the low patient volume accessing ART in this clinic did not merit the efforts to meet accreditation requirements. According to the practitioners interviewed, the number of ART clients supported at PHPs facilities equivalent to HC IV-level ranged from 20-100 (considered low volume) while the NGO and PNFP facilities of the same level supported anywhere from 600 to more than 6,000 (considered high volume).

There is a general lack of clarity with regard to fees charged for HIV/AIDS and ART services by both PNFPs and PHPs accredited to access free supplies. While recent case studies state that the MoH requires facilities to dispense the drugs free of charge (AIDSTAR, 2009), both facilities and MoH/GOU staff interviewed had a wide range of interpretations of what this means in practice. Some facilities (even PHPs) do not charge patients for any HIV/AIDS services apart from drug prescriptions, while others charge for all or some services, including drugs – sometimes at a lower rate.

Some facilities, like Mengo Hospital’s HIV/AIDS clinic (a PNFP facility), provide standard HIV/AIDS services (ART, PMTCT, SMC, HCT, care) for free or a nominal fee (UGX 2,000), but charge extra fees for ancillary services such as some diagnostic services, mental health, physiotherapy, ANC (as a flat fee for a package of unlimited ANC services) and labor/delivery.

Some MoH respondents reported that there is no strict guidance on how private sector facilities should or should not collect fees under the ART accreditation program, and one even suggested the government should provide a small monetary supplement in addition to free supplies to cover overheads. A 2015 retrospective health-seeking behavior survey conducted under USAID’s Strengthening Health Outcomes through the Private Sector (SHOPS) in Uganda showed that ART patients often switched between sectors when deciding where to access HCT, initial care, and ART (SHOPS Research Insight, 2015).

Box 6.3 Quality Improvement Initiatives to Strengthen Service Delivery in the Private Sector: The Case of Two Private Hospitals

For quality assurance of ART delivery, the MoH aims to regularly assess health facilities against standards throughout the year, though in practice this is reported to rarely occur due to lack of resources. Consequently, the Development Partners and Implementing Partners joined forces to assist the MoH to support quality improvement (QI) in the private sector. This initiative, in partnership with USAID/ASSIST, uses a continuous quality improvement (CQI) approach to improve quality of SMC services at Mehta Hospital and Kinyara HC III. The two facilities provide comprehensive HIV care, treatment and support among other services. At the beginning of 2014, these facilities were assessed for quality of SMC services.

The assessment looked at: management systems; supplies, equipment and environment; registration, group education and IEC; HIV counselling and testing; SMC surgical procedure; infection prevention in SMC services and monitoring and evaluation. The baseline showed very poor performance of both facilities scoring 0-53% in most areas except supplies, equipment and environment, and infection prevention.

Health Unit	Management systems		Supplies, equipment & environment		Registration group education and IEC		HCT		SMC surgical procedure		M&E		Infection prevention	
	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
Mehta Hospital	40	80	83	100	0	100	-	100	-	88	14	86	84.6	100

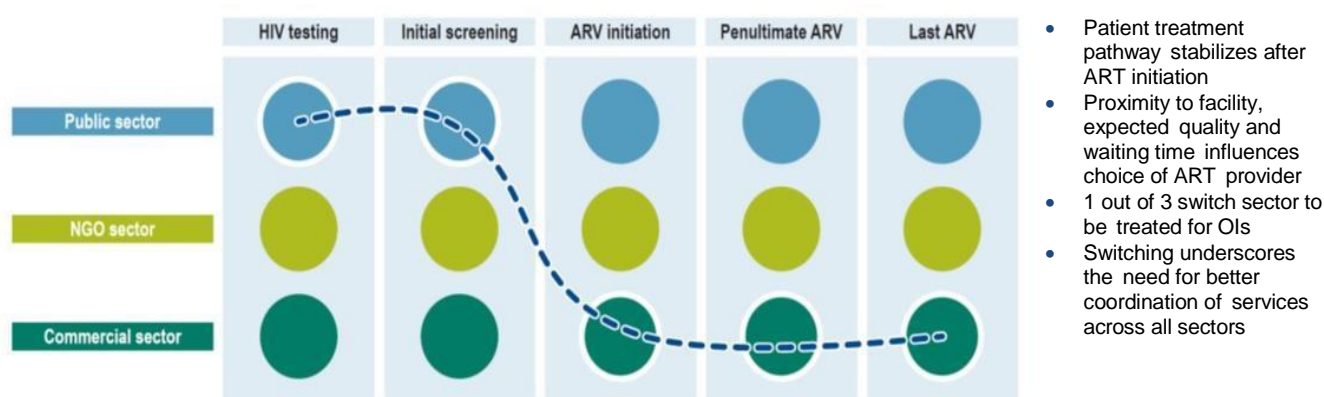
The CQI approach involved constant support of the staff in these facilities through continuous training health workers in SMC/QI strategies; attending SMC QI learning sessions and site-based QI coaching and mentorship sessions. The health workers at both sites formed site-based QI teams, identified and implemented QI projects. The projects were evaluated on a quarterly basis to assess performance, identify the good practices, identify areas for improvement and develop new projects.

A follow up assessment in February 2015 showed improvement with scores ≥ 78% in all the areas except registration, group education, HTC and surgical procedure (these areas were not assessed at baseline, as there were clients at the facility at the time of the visit). By September 2015, the facilities showed consistent quality improvement in care across the SMC cascade. These interventions will be institutionalized in the facilities to form part of staff and performance review meetings. However, the key challenge remains high staff attrition affecting continuity of QI activities requiring new staff re-training and mentorship.

Lessons learned: Strengthening CQI strategies in the private health sector is feasible through learning sessions, mentorship and coaching. QI learning sessions provide appropriate fora for health workers to share experience, knowledge, good practices and challenges.

Proximity, quality, waiting time, and provider recommendation/referral were factors influencing choice of facility for ART. While treatment pathways tended to stabilize after initiating ART, a third of patients were found to have switched from their ART provider to another sector (public, PHP, or PNFP/NGO) to receive treatment for opportunistic infections (see Figure 6.12). Of concern, the study also found that 10% of respondents knew someone who had acquired ARVs from two or more facilities at the same time; reasons cited for this included selling them, providing medication for a friend, or avoiding ART stock outs. One common pattern that emerged was that a large number of patients accessing HCT from the public sector, eventually switched to the NGO/PNFP sector for HIV care and ART. According to the PSA respondents, these patients were likely from the poorest or working poor socioeconomic classes, demonstrating that the ART treatment pathway is somewhat fluid amongst these quintiles.

Figure 6.12 Pathways to HIV Care Framework



Source: SHOPS Research Insight, 2014

One gap all respondents agreed on is that the private sector is serving HIV patients who would not otherwise access services due to enduring stigma around HIV status. As one respondent described, HIV patients with even small means to pay for services will often choose to access service from the private sector rather than experience stigma stemming from something as simple as “others seeing your car parked at TASO” (TASO is a well-known national HIV NGO). ART clinic days at public and some private facilities, which often feature long waiting times in the open outside a facility building, were cited as a prime example of how easily community members can learn who is HIV-positive. Private facilities, particularly PHPs offering comprehensive services including HIV/AIDS, are a “one stop shop” that provide convenience, privacy, and flexibility. Some PHP practitioners described their ART clients as “walk-ins,” and others reported that PHP facilities provided timesaving measures such as call-in ARV prescriptions for clients. As seen in the SHOPS study, patients are also switching between sectors 30% of the time as they progress along the treatment pathway.

6.2.6 Challenges Private Sector Providers Face Delivering HIV/AIDS Services

Most PHPs cited staff turnover as their greatest challenge, and they most often see staff leave after having invested considerable resources in training them and take up positions in both the public and PNFP sectors.

Respondents reported that the public sector’s government benefits, including training and further education, are attractive, while the PNFPs offer more enjoyable working conditions and higher salaries. However, the majority of PNFPs interviewed (both small and big ones) also reported high staff turnover from PNFPs to the public sector because of better salary levels and better working conditions (e.g. reduced workload and continuous education). It would be interesting to study the dynamics underlying these staff movements either way.

Stakeholders at both policy and facility level noted that PHP staff salaries are often generally lower in order to increase profit margins, and PHP expectations for better customer care can be challenging for workers who were trained in the public sector. Some PHP owners reported that they are concerned that offering lower salaries may affect the quality of their staff, and therefore their services. However, they face a great dilemma in providing necessary skills training for staff, knowing workers will likely leave for better positions. The majority of PHPs interviewed reported that they struggle to earn a marginal profit, or even to meet costs. Their reported revenues ranged from UGX 15 – 70 million per month, while PNFPs reported revenues between 1-200 million per month. PHPs cited increasing drug prices as their top cost driver while PNFPs cited cost of equipment (buying and repairing), staff and for the bigger ones, external quality assurance (SANAS, South Africa; KENAS, Kenya; CAP, USA; and NEQAS, UK). Patients seen per day ranged from 20 to more than 50 for PHP clinics in comparison to PNFPs who generally reported 100-350 per day. All PHPs and PNFPs stated that they have waived fees in special cases for patients who could not pay (this was more prominent in PNFPs), though practitioners do not have a standardized methodology to assess or verify inability to pay. Mark-ups on drugs are largely arbitrary; some compare prices with competitors in the market, but most PHPs cited setting arbitrary small margins for expensive drugs and larger margins for cheaper drugs. Most noted that they cannot set prices too low for drugs, or patients will suspect they are counterfeit.

Many PHPs also noted that taxes and other regulatory fees are a challenge in maintaining enough revenue to recover costs. Due to PHPs “for profit” status, registration fees for PNFPs are lower, and PNFPs are exempt from most taxes. In planning for service expansion, many newer practices (both PHP and PNFP) plan to apply for loans, though some cited collateral requirements as an insurmountable barrier. All PNFPs visited indicated that the biggest barrier to expansion is lack of access to capital – as a not-for-profit they are ineligible to apply for commercial loans and there is no government program providing access to capital.

However, some PHP providers who have been in operation for more than a decade refuse to seek loans, stating that they have seen many colleagues’ practices fail under loan payments for equipment or services for which there was declining or changing patient demand. Some also reported that they increasingly see their patients “shopping around” – requesting and paying for diagnostic services, only to seek treatment at a cheaper facility (see Box 6.4).

Box 6.4 Crowding Out of PHP Providers Delivering HIV/AIDS Testing and Treatment

Goodwill Polyclinic, a PHP owned by Director/Owner Dr. Benson Adongakulu, opened its doors in Kampala in 1997. With time, Dr. Adongakulu opened a second branch in Gulu. Over the years, he witnessed a change in his patients’ demand for services. Patients initially accessed his clinic for an initial diagnosis, and then went elsewhere for treatment. Currently he notes that an economic downturn has had a direct impact on his ability to stay in business. Often, these patients leave to go to private clinics that are allegedly run by MoH doctors who run a private practice in the evenings and who are rumoured to be taking drugs and supplies from public stocks. As the drugs are presumably stolen, these providers are then able to offer them at a reduced price compared to the surrounding PHP market. Dr. Adongakulu believes the cheaper prices are driving patients away from Goodwill Polyclinic. In the North, PNFP facilities that are highly subsidized with donor funds are also able to offer services at very low cost to patients. As such, Dr. Adongakulu’s Gulu branch is also seeing fewer patients, and he feels that the only way to stay in operation is to receive donor funding. He stated that if he were to expand services through a grant, it would only be for diagnostics in order to capitalize on patient behavior. Otherwise due to dwindling resources, Dr. Adongakulu is strongly considering leaving medicine altogether and taking up agriculture after 19 years in practice.

The majority of PHP patients pay cash for services rendered, though many facilities in Kampala cited a growing acceptance of formal employee-sponsored insurance schemes as well. However, those with higher numbers of patients paying through insurance reported general dissatisfaction with and distrust of insurance providers. From their perspective, insurance companies “squeeze” the health provider by setting payments for drugs and services lower than rising costs of drugs and overheads, disallowing the health provider’s diagnostics or course of treatment after the fact as unnecessary, and delaying payments for months while

the provider's overhead bills are usually monthly. Some also reported that insurance providers would pay for selective standard services, but then require that a patient be referred out to other providers for more specialized, greater fee-bearing services. Some told stories of foreign-owned insurance companies starting up quickly, and then going out of business without having paid providers for services rendered. For these reasons, dissatisfied PHPs are considering or have terminated contracts with insurance companies, and are wary of the developing NHIS.

6.2.7 Public-Private Interactions in HIV/AIDS Sub-Sector

While PNFPs have a close relationship with the public sector, no PHP respondent could report a formal contract, MOU, or regular interaction with the public sector other than informal referrals, infrequent support supervision, provision of ARVs and vaccines, data reporting and, indirectly, through dual practice. Most private practitioners reported that the public sector and external donor funders are generally "closed" to the participation and value of the private sector in health care delivery. PNFP respondents acknowledged that the government is perceived to be more open to engaging the PNFP subsector than PHPs. Many stated that at policy level there may be commitments to engaging with the private sector in planning and service delivery, but in terms of operationalization, and particularly financing, these pledges are often vague or dissipate altogether. Some stated that champions of the private sector exist in the public sector, but these are rare and affiliated with certain health areas, such as HIV/AIDS. Others expressed hope that if the NHIS materializes and is governed properly, this may open lines of communication and engagement with the public sector. The majority of facilities interviewed are not aware of the PPPH Policy, or of plans for the AIDS Trust, though many are following the NHIS developments closely.

Referrals between the public and PNFP/PHP subsectors, as well as between facilities in the private sector, are frequent and informal. Due to stock outs, staff shortages, non-functional equipment or general lack of capacity, neighboring public sector facilities often refer patients for diagnostics and treatment. All PHPs responded that they provide services for patients referred from public hospitals and HC IVs, and at times, do not charge the referred patient a fee depending on the patient's economic conditions. For complicated cases beyond their capacity, PHPs will refer patients for diagnostics and treatment to PNFP, other PHP, and public facilities, depending on the level of care required. Since the referral system in Uganda is weak and patients are often lost between facilities and for follow up care (HSA, 2011), respondents reported that providers (both public and private) would refer patients to their personal network. PHPs often provide a choice to patients, and those who are able to pay are referred to PNFPs or other PHPs. PHP respondents also cited that they provide physical referrals for patients via ambulance or with a health worker as this gives assurance that the patient reaches their destination. However, they reported that patient follow up is difficult, and even when the patient returns to their practice, it is challenging to secure accurate information on their previous diagnostics or treatment, particularly if they had been referred to Mulago Hospital for secondary or tertiary care.

The regularity of supportive supervision provided to the private sector varies as reported by the PSA respondents. Those who are larger, have more ART clients, or operate more comprehensive referral labs generally receive support supervision quarterly as scheduled, mainly because of external donor support of these vertical programs through PEPFAR implementing partners.

When asked their opinions on representation of the private sector at national level, all PHP respondents wanted to see a unified PHP representative to engage with government, though suggestions for such an entity varied. Some stated that having an umbrella group such as the PNFP medical bureaus would address fragmentation and help standardize quality. Some also stated that the Uganda Private Practitioner's Association is already the sector's representative, though unsuccessful to date in engaging with the MoH. Others cited other associations (UHF, PSFU) and the PPP Node as possible candidates for this role. Some

practitioners preferred a donor-funded “impartial” implementing partner like the Program to play this role. All agreed that no one individual would be an appropriate representative and that any attempts to elect such a representative would likely be mired in controversy and difference of opinion.

While no PHP respondents³⁰ had formal agreements with the MoH or government, almost all stated that they would welcome greater partnership and engagement that is more formal. Most respondents also encouraged service contracts, future NHIS contracts, grants, vouchers, subsidies and tax breaks as possible partnership vehicles. Similarly, the MoH could issue competitive grants or facilitate “soft loans” to assist PHPs to purchase equipment (especially diagnostic equipment) or drugs.

Take Home Messages on HIV/AIDS Services and the Private Sector

- Nearly all private sector providers reported they would welcome more formal interaction with the public sector through contracting, subsidies, donations, tax breaks, or other financing mechanisms. All would like to see more feedback on performance as well as regular updates on clinical guidelines and other guidance from the MOH.
- Most PHPs, while often perceived as “in it for the money,” as one respondent described, are largely earning marginal profits and struggle to meet costs on a regular basis. Most base their fees and drug markups on arbitrary methodologies rather than formal willingness-to-pay or costing information, and do not have strong business skills to analyze revenues, cash flow and financial/operational inefficiencies.
- PHPs acknowledged that private practitioners providing the highest quality services are often those supported by a donor-funded implementing partner. Alarming, one of the largest PNFs interviewed stated that they have an almost total reliance on PEPFAR grants, and should funding cease the HIV clinic serving upwards of 6,000 ART clients would close in a matter of months.
- Formal employer-sponsored insurance schemes have not been largely successful amongst interviewed private providers and this experience may dissuade providers from eventually joining an NHIS program.
- While PNFs are generally better able to report to the various required databases, including DHIS2, PHPs are often not able or willing to do so due to time and resource constraints in completing manual paperwork and lack of qualified staff for proper data management. Disseminating regular feedback from the MOH/district may help address this issue. If this reporting gap is not improved, PHPs may soon find themselves excluded from donor and government support due to current emphasis on data-driven interventions.
- While PHPs are not generating as high of ART patient volumes as the PNF subsector, it is clear that overall the private sector offers considerable infrastructure and resources to help meet Uganda’s aggressive ART scale up targets if leveraged and coordinated effectively. This has already been acknowledged in UAC’s HIV Investment Case.
- Private sector providers are playing an essential role in addressing health-seeking behavior of HIV patients concerned by stigma. Due to staff shortages, stock outs, crowding and other pressures, ART patients in the public sector often do not receive treatment on time; the flexibility of the private sector generally allows patients to receive treatment on schedule.

³⁰ Kakira Hospital – a PFP hospital – maybe the sole exception. They receive PHC funds from the MOH because it is the only major hospital in the entire sub-county in Jinja district

6.2.8 Recommendations to Harness the Private Sector in HIV/AIDS

The PSA team recommends the following actions to better leverage private sector providers' contributions to HIV/AIDS:

1. **Conduct regular NASAs.** The first and only NASA conducted in 2012 has not been repeated due to the approach used, which was too costly to perform additional assessments. UAC reports that it is negotiating with MAKSPH to collaborate on future NASA studies in order to increase efficiencies. With an intense focus now on ART service provision, having up to date spending data in HIV/AIDS services will be essential for effectively leveraging the private sector, where most of the resources for services being spent as indicated in the NHA.
2. **Allow private providers to access scholarships and other public sector professional development programs.** Respondents reported that the greatest challenge they face is staff attrition, often to the public sector. Many staff are attracted to professional development opportunities such as scholarships for degree programs and other training afforded to public sector workers. Continual staff turnover directly affects quality of service delivery. With 50% of services delivered by the private sector, opening up continuous professional development (CPD) benefits to private health workers as well as public will help maintain and improve quality and consistency across the health sector.
3. **Set fees for services under the ART accreditation program.** With no clear guidance or enforcement of fees waived for HIV/AIDS services in exchange for ART accreditation, patients cannot be certain of which services or drugs will require payment. This may serve as a barrier to access for the poorest ART clients who prefer to access a PHP. The MoH should clarify, disseminate, and enforce fee guidelines to accredited practitioners, provided these guidelines allow private providers (both PHP and PNFP) to meet costs, cover overheads and earn profit on supplementary HIV/AIDS services. Robust costing studies should inform these guidelines.
4. **Ensure all US Government and donor agencies appreciate the strengths and weaknesses of the private sector.** To date USAID has been the traditional supporter of private sector contributions to Uganda's health system. With donor portfolios changing dramatically, ensuring a balanced understanding of the benefits and limitations of the private sector will be critical to leveraging its resources for greater health impact. Particularly vital will be the strengthening of monitoring and reporting capacity so that the private sector contribution is not only accurately quantified, but also regularly utilized in overall decision-making.

Aside from the policy recommendations, the PSA team recommends exploring several concrete partnership opportunities with the private sector that have demonstrated success in both SSA and other developing countries.

5. **Segment those who can afford to pay and "steer" them to the private sector.** As the UDHS shows, PHPs currently play a small role in PMTCT services yet private physicians and midwives have expressed interest in expanding services in this area as a strategy to offer comprehensive services for all their mothers. As a cost-saving measure, the PSA Team recommends the strategy to "steer" women from the top income groups to private providers. Significant percentages of pregnant women in the top three income groups (middle – 92%; richer 87% and richest 77%) receive highly subsidized services in public and PNFP facilities yet they have some ability to pay. Directing those who can afford to pay will free up scarce public resources that could be redirected to reach under-served pregnant women. Strategies to direct women to PNFP and PHPs providers include: i) establishing pricing guidelines for PMTCT services to influence PNFP and PHP prices;

ii) re-examining the MoH policy of free services to enable MoH facilities to charge and/or refer higher income women to the private wings of public facilities for PMTCT services; and iii) transferring this segment to PNFPs and PHPs through a formal referral mechanism (see below).

6. Contract private midwives to expand and integrate PMTCT into their current services.

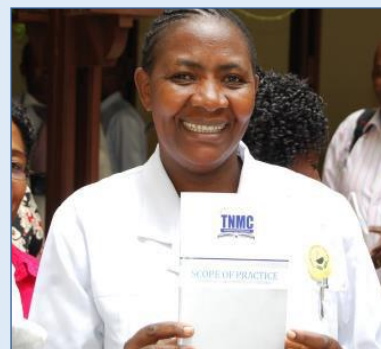
Private midwives are located throughout Uganda and even in many of the rural communities. They play a critical role in maternity and other health services in their community. Often these private midwives are the only primary healthcare professional in their community. Indeed, several countries in the region – Kenya and Tanzania to name a few – have expanded the scope of nursing and midwifery general practice and promoted responsible and enhanced task sharing to respond to HIV and other priority health challenges. The expanded scope of practices has opened the door to private midwives in Tanzania to offer PMTCT B+ services to women in their community (See Box 6.5).

Box 6.5 Tanzania Partnership with PRINMAT to Expand PMTCT Services

In response to HRH shortage and HIV/AIDS crisis in Tanzania, the Ministry of Health and Social Welfare expanded the scope of nursing and midwifery general practice and promoted responsible and enhanced task sharing to respond to HIV and other priority health challenges. Through a consultative process involving the MoH South West (SW) chief medical officer and a range of medical, laboratory and pharmacy stakeholders, the MoH developed a draft of the first ever nursing and midwifery scope that include PMTCT. The scope was ratified in 2014.

Following its ratification, MoH SW gave the nurses and midwives association -PRINMAT - access to its training curricula trained the PRINMAT providers and helped them prepare their facilities.

After the training in clinical guidelines and government reporting, PRINMAT facilitated linkages between their members and the local district medical officers. PRINMAT providers receive quality supervision and mentorship from physician mentors from nearby facilities. In addition to expanding their practice to include PMTCT B+ services, PRINMAT midwives have received training to provide the full adult ART regime. Several PRINMAT midwives have demonstrated their ability to apply this new skills area and increase PMTCT access quickly. Through PRINMAT, their private midwives conducted 18,713 HIV test to adults and children and initiated 318 pregnant mothers on ART during the partnership's first 9 months.



The PSA Team recommends pursuing a similar strategy but expanding it to include performance based contracting. Unlike other private provider groups, private midwives are well organized under the Uganda Private Midwives Association (UPMA) and other private midwife networks like PACE and Marie Stopes-Uganda. UPMA is a readily available partner as they already work closely with the MoH to supplement the GOU efforts by providing integrated reproductive health, HIV/AIDS, and primary care services. Currently UPMA has a membership network of 708 private midwives with 12 branches located nation-wide (UPMA Data, 2016). PPP activities that exist elsewhere include: i) expanding nursing and midwifery scope, ii) training eligible providers in PMTCT B+, iii) donating necessary commodities such as HIV test kits, dried blood spot test kits and ARVs, iv) including private midwives in all donor-supported training, v) establishing a formal referral mechanism, and v) issuing competitive service contracts for networks and allowing numerous organizations to respond. (See examples of contracting in Section 4).

7. **Formalize and strengthen the referral system.** As highlighted by key informants, the referral system continues to be ineffective and costly for the poor. The Uganda Health Systems Assessment, 2011 reached the same conclusion (MoH, Health Systems 20/20, MAKSPH, 2012). Informal referrals are already frequent between the public and private sectors for both diagnostics and treatment, with referred patients sometimes, and sometimes not, paying PHP practitioners. As seen in the SHOPS study, 30% of patients switch between sectors as they progress along the treatment pathway. Formalizing the referral system, perhaps through a down-referral contracting model such as the one in South Africa’s North West Province (see Box 6.6), would take pressure off the public system, limit multiple prescriptions of ARVs for personal gain, and improve loss to follow up amongst ART clients.

Box 6.6 South Africa Down Referral Program in HIV/AIDs and other Chronic Diseases

In partnership with the North West Provincial Department of Health (DOH) in South Africa, BroadReach Healthcare (BRHC) established a “Down Referral Model” to alleviate some of the burden on the public sector by leveraging the private sector in the treatment delivery for people living with HIV/AIDS (PLHA). Patients are initiated at a public healthcare facility, the Wellness Centre, where they are stabilized for six months. The BRHC office is physically located in the Wellness Centre where stable patients are identified by a Wellness Centre doctor and immediately referred to the BRHC Down Referral program.



This identification and referral process takes place daily. Patients are then referred to a private general practitioner (GP) or clinic for continued government-funded treatment. Patients are referred to GPs based on geographic convenience for the patient and the BroadReach team makes the first appointment. This referral and registration process for new patients to become active in the program only takes 1 day. Should a patient acquire an opportunistic infection or require treatment for another condition, they are referred back to the Wellness Centre, and then again to the private GP/clinic once stabilized. Adherence interventions are tailored to the needs of each patient, and range from SMS reminders, workshops and support groups, to a series of home visits by an adherence counsellor.

To make this partnership work, each partner has a role to play. The DOH trains, mentors and monitors participating private GPs as well as donates ARVs for MOH patients in the program. The private provider is only allowed to charge for the clinic visit and focuses on adherence support by engaging the patients’ family and buddies through HIV positive peer educators and speakers. The private GP’s quality of care is monitored by a third party - Aid for AIDS - the largest Disease Management Organization (DMO) in South Africa.

The DOH and BRHC strategically crafted a Memorandum of Understandings between the two parties that anticipates eventual withdrawal of USAID funding. The MOU stipulates the negotiated and agreed upon fee that the GPs can charge to ensure they can stay in business while the DOH put in place plans to absorb program costs and continue operating the program.

The Down Referral Model has been so successful in the area of HIV/AIDs, that the MOH expanded the program to down refer stable hypertensive patients, with plans to phase in the down referral of stable patients diagnosed with epilepsy, diabetes, and asthma. Additionally, discussions are currently underway with DOH NW to begin down referral of patients initiated at Tshepong Hospital feeder clinics into the program. This will ensure continued capacity to enroll new patients at feeder clinics through the national Nurse Initiated Management of ART (NIMART) initiative.

Source: <http://healthmarketinnovations.org/program/broadreach-healthcare-down-referral-model>

8. **Network Private Pharmacies to treat Opportunistic Infections.** With over 6,500 pharmacies and drug shops located nationwide, they reach even remote areas in Uganda. Pharmacies and drug shops are often the first place people go for common health issues. They are a preferred – and sometimes the only - source of healthcare information and services.

However, the majority of pharmacies and drug shops are privately owned and not well integrated into the overall health system. The sheer size and number make private pharmacies and drug shops a potential opportunity to extend reach of HIV/AIDs and TB related services.

There is a growing experience in several developing countries (e.g. India, Jamaica, Kenya, Philippines, St. Kitts, Tanzania, Vietnam) where the MoH works with private pharmacies and/or drug shops to deliver essential medicines to treat a wide array of diseases. The PSA Team recommends harnessing private pharmacies and drugs shops through a similar approach used in Vietnam (see Box 6.7) to treat opportunistic infections and TB (See Section 7 on essential medicines for an in-depth proposal on mobilizing private pharmacies and drug shops).

Box 6.7 Private Pharmacies Treating OIs and TB in Vietnam

PATH in Vietnam assisted the Department of Health (DOH) to train 1000 private pharmacies in 5 districts to deliver OI and TB services. With evidence from a needs assessment, PATH worked with DOH officials in each province to develop training and reference materials, train 244 master trainers who then trained 5,433 private pharmacy owners, pharmacy staff, and supervisors. PATH also worked with medical schools to integrate the training curricula into the schools' training for pharmacy students. To support the newly trained pharmacy staff, PATH built DOH provincial teams of supervisors on supervision skills, provided needed tools, and facilitated supervisory visits. They also trained DOH staff to use the mystery client approach as a supervision tool.



The project also established a referral system between private pharmacies and DOH facilities which included referral slips. PATH also organized regular workshops between private pharmacies and public facilities to promote referrals and networking. Community education is also a strong component. PATH created a logo to brand participating pharmacies and trained village health workers, Women's Union and Youth Union to provide health information and refer to participating private pharmacies.

(Source: https://www.path.org/publications/files/CP_vietnam_pharmacies_br.pdf)

6.3. Private Sector Contribution to Maternal and Reproductive Health Services

The health of a mother affects the family and entire community. Her ability to access and receive necessary health care greatly determines health outcomes for herself and her baby. Uganda is one of ten countries globally which contribute to the highest maternal, newborn and child mortality rate in the world (WHO, 2011). With maternal and prenatal health conditions ranking as the fourth leading cause of disease burden in the country, more needs to be done to ensure safe motherhood (Global Burden of Disease Study, 2010). The reasons for the poor health outcomes of mothers and children in Uganda are well documented; health system challenges and poor social determinants negatively impact maternal child health, difficulty in accessing quality services, shortages of trained and motivated health professionals and shortages of essential drugs contribute to high mortality and morbidity rates, access to life-saving services and medicines is also inequitable.

6.3.1 Background on Maternal and Reproductive Health

There are vast inequalities across maternal and infant mortality globally, with the developing world accounting for the majority of the burden. Many factors limit the utilization of maternal and RH services in developing countries. These factors include the availability, accessibility, and quality of services as well as the characteristics of the users and communities in which the users live. Key socio-economic factors include: (i) education level of both mother and father,^{31,32,33} (ii) place of residence,³⁴ (iii) decision-making autonomy,³⁵ (iv) cultural values,^{36,37,38,32} and (v) ability to pay.^{32,39,40} The UDHS 2011 provides a wealth of information on where women seek their maternal/RH services.

Although Uganda has made significant investments to improve the health of its citizens, its health indicators remain a concern. Challenges remain in ensuring that women, children, families, and communities have access to high-quality health services, whether it is safe delivery for pregnant mothers and their newborns or reproductive health counseling and contraceptives for individuals and couples.

Table 6.3 Trends in Uganda's Maternal Health Indicators

Indicator	2000/01	2006	2011	2014 WHS Estimates
Life expectancy at birth (years)	50.4	-	-	63.3
Under 5 mortality rate (per 1000 live births)	152	137	90	69
Neo natal mortality rate	33	29	27	23
Infant mortality rate (per 1000 live births)	88	76	54	45
Immunization coverage (% fully vaccinated 12-23 months)	29	36	40	
Maternal mortality ratio (per 100,000 live births)	524	435	438	360
Birth assisted (%)	-	41	40	44.4
Modern contraceptive rate (% of married women who use)	18.2	17.9	26	-
Total fertility rate	6.9	6.7	6.2	-
Unmet need for FP (%)	35	38	34	-

Source: HSDP 2015/16-2019/20; AHSPR 2009/10 2014/15; UDHS 2011; UBOS 2016, WHO, 2014
Source: Health Sector Development Plan 2015/16-2019/20, UDHS 2011, UBOS, 2016, WHO, 2014

³¹ Source: <http://www.bioline.org.br/pdf>

³² Rutaremwa G, Wandera SO, Jhamba T, Akiror E and Kiconco A. Determinants of maternal health services utilization in Uganda. BMC Health Services Research (2015) 15:271

³³ Ricketts TC, Goldsmith LJ. Access in health services research: The battle of the frameworks. Nurs Outlook. 2005;53: 274–280.

³⁴ Source: <http://scholar.harvard.edu/files/joshuagoodman/files/parentalses.pdf>

³⁵ Anyait A, Mukanga D, Oundo GB, Nuwaha F. Predictors for health facility delivery in Busia district of Uganda: a cross sectional study. BMC Pregnancy Childbirth. 2012; 12.

³⁶ Kwagala B. Birthing choices among the Sabiny of Uganda. Health and Sexuality: Culture; 2013.

³⁷ Kyomuhendo G. Low Use of Rural Maternity Services in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources. Reprod Health Matters. 2003; 11:16–26.

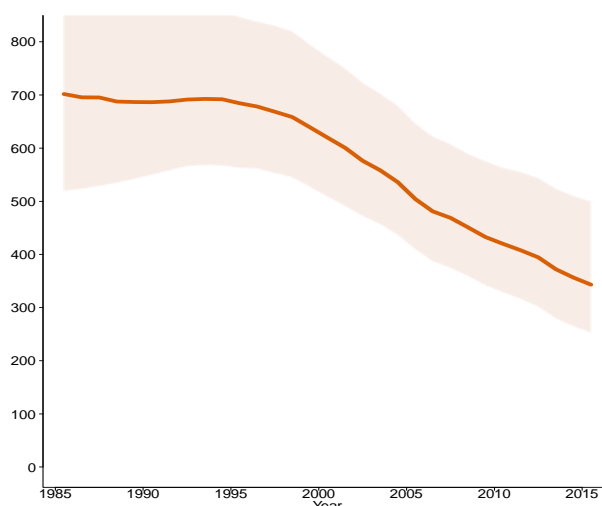
³⁸ Kabakyenga JK, Östergren P-O, Turyakira E, Pettersson KO. Knowledge of obstetric danger signs and birth preparedness practices among women in rural Uganda. Reprod Health. 2011;8.

³⁹ Asiimwe, K.J. 2010. Utilization of antenatal services among adolescents in Western Uganda, 2007.

⁴⁰ Source: <http://www.bioline.org.br/pdf>

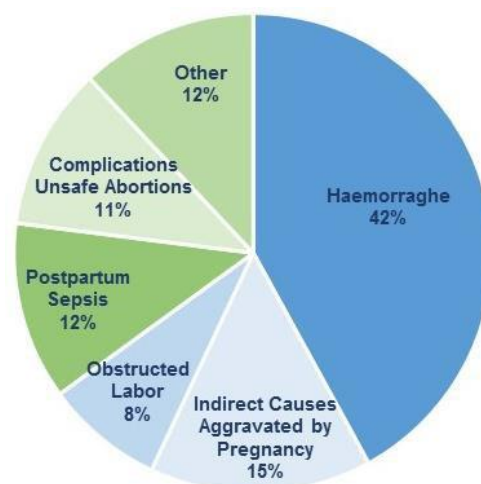
Maternal Mortality. Statistics from the draft Uganda Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA) Sharpened Plan, 2016, the maternal mortality ratio (MMR) has fallen by approximately 50% over the past 20 years, but still falls short of the MDG target, which called for a reduction of at least 75% in the MMR by 2015 (see Figure 6.13). WHO estimates that 5,700 maternal deaths will have occurred in Uganda in 2015, yielding an overall MMR of 403 maternal deaths per 100,000 live births. Almost half of the determinants of maternal mortality lie outside of the health sector and in order to accelerate MMR reduction, there is equal need to invest in social determinants including girl child education, women empowerment, and water and electricity in health facilities (MOH, 2016⁴¹).

Figure 6.13 Trends in Maternal Mortality, Uganda



Source: MoH, Draft RMNCHA Sharpened Plan, 2016

Figure 6.14 Direct Causes of Maternal Mortality



Source: Maternal and Perinatal Death Review (MDPR), 2013/14

The immediate causes of maternal death are hemorrhage accounting for 42% of deaths (Figure 6.14), followed by obstructed or prolonged labor (22%) and complications from abortion (11%). Indirect causes include malaria, a factor in 36% of maternal deaths recorded, anemia in 11% and HIV/AIDS in 7% (MoH, 2016⁴¹).

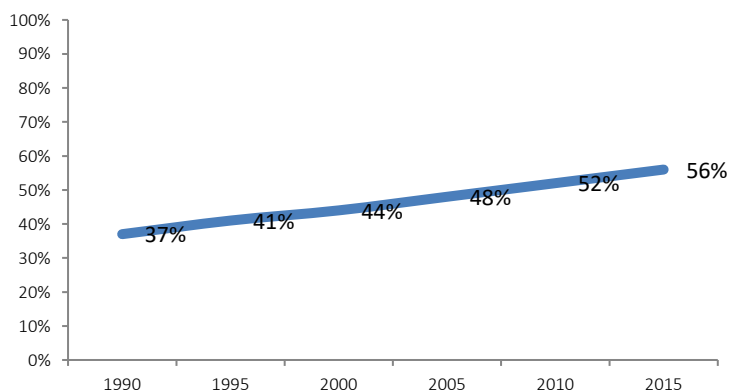
Antenatal Care. According to the UDHS 2011, there is universal access to ANC services in Uganda, with 95% of all-pregnant mothers receiving ANC services from a skilled provider. However, only 21% of women made their first ANC visit before the 4 months of pregnancy in 2011 and the median gestation age for the first antenatal visit was 5.1 months. Attendance of at least four ANC visits between 2006 and 2011 has stagnated at 48%.

Institutional Delivery. The proportion of births supervised by a skilled health worker rose from 38% in 1995 to 58% in 2011 (UDHS 2011). However, a significant proportion (42%) still delivers at home. Although almost ninety percent (89%) of all births in urban and 53% of births in rural areas are attended to by a skilled birth attendant, regional disparity still exists. Karamoja and the South-Western regions experience the lowest coverage of deliveries supervised by a skilled provider at 31% and 42% respectively.

⁴¹ MoH, 2016. Reproductive, Maternal, Newborn Child and Adolescent Health Sharpened Plan for Uganda.

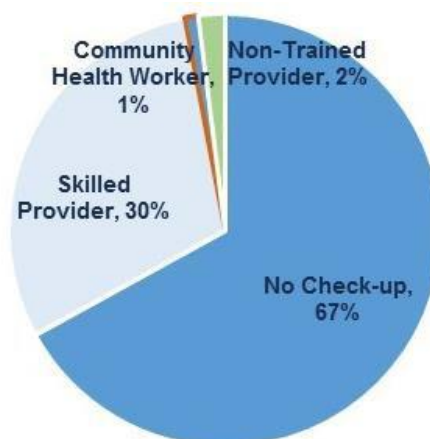
Postnatal Care. In addition, more than two thirds (67%) of mothers do not receive any postnatal check-up (See Figure 6.16), yet over 67% of maternal deaths occur 23-48 hours after delivery. The commonest causes of maternal death are hemorrhage and hypertensive disorders or sepsis after 48 hours.

Figure 6.15 Trends in Institutional Deliveries, Uganda



Source: MoH, Draft RMNCHA Sharpened Plan, 2016

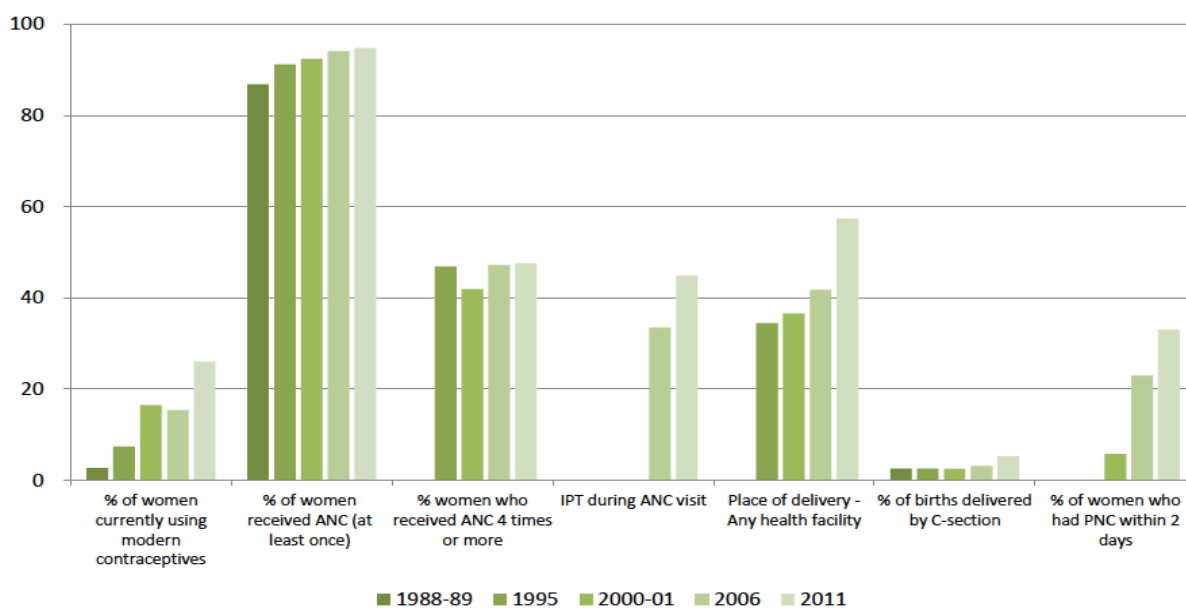
Figure 6.16 Source of PNC Provision



Source: MPDR 2013/14

Family Planning (FP) and Reproductive Health (RH). Uganda has one of the highest rates of unmet need for FP in SSA – 34.3%, which translates to approximately 1.6 million women (PRB Brief, 2011). Of these women, about 60% want to space their next birth and the other 40% do not want any more children. More than half (64%) of married women who are non-users intend to use FP in the future; this proportion has not significantly changed for the last decade. The UDHS 2011 shows that Ugandan women, on average, give birth to nearly two children more than they want (6.2 instead of 4.5). Moreover, approximately 43% of all pregnancies are unplanned. Contraceptive use among all married women or those with a partner doubled from 15% in 1995 to 30% in 2011. Figure 6.17 provides an overview of the trends in key maternal health indicators from 1988 to 2011.

Figure 6.17 Coverage Trends across Continuum of Maternal Health Care in Uganda



Source: UDHS Survey

6.3.2 Maternal Health at the Policy Level

In Uganda, the regulations for supervising PHPs that deliver maternal health care are shared between government statutory bodies and non-government professional associations. The key actors are the Uganda Nurses and Midwives Council (UNMC), the Uganda Nurses' Union, the Uganda Nurse and Midwives Examination Board (UNMEB) and the Uganda Private Nurse Midwives Association (UPMA). UNMC's mandate is to regulate nurses and midwives to ensure professional standards and ethics are adhered to in addition to maintaining facility and professional licensure. UPMA is playing an increasingly important role in ensuring their members are compliant with Uganda's regulations and observe clinical standards and guidelines. UNMEB on the other hand handles all examination related issues.

The GOU has put in place several initiatives in an attempt to improve women's status in Uganda (see Table 6.5). The National Population Policy seeks to slow down population growth and reduce fertility by promoting informed choice for FP and increasing access to quality health services. The policy also involves other sectors such as education, health, agriculture and the economy, as strategies to promote changes in cultural practices that influence reproductive health decisions. In 1996, the government adopted Universal Primary Education as a strategy to improve the population's literacy and to increase girl's enrolment and retention in school. The government also adopted a gender policy in 1997 with the goal of integrating gender into community and national development. There have also been several attempts to legislate against negative social practices such as domestic violence, polygamy, and inequity in family resources but with limited success (Health Systems Development, 2003).

Table 6.5 Policies and Plans Supporting MCH

Policy or Plan	Key Points and Private Sector References
<p>National Population Policy (1998 and 2008)</p> <p>National Population Policy Action Plan</p>	<ul style="list-style-type: none"> • The policy seeks to reduce population growth and develop human capital through multi-sectorial approach. Policy divided into five categories – 3 directly influence women’s health • Population and Development: The NPP is directly linked to the National Development Plan. Actions include improving the quality and retention at primary and post primary education levels, reducing infant, child and maternal mortality rates and increasing people’s control over the size of their family. • Sexual and Reproductive Health: Informed choice and mutual and equitable gender relations are the underpinning to sexual and reproductive health. Actions include increasing access to safe, affordable and acceptable FP methods and reproductive health services. • Gender and Family Welfare: Socio-cultural influences and weak economic power limit both men and women’s reproductive rights. Actions include providing appropriate information, advocating for positive change in gender and family welfare issues.
<p>Safe Motherhood Programme (1999)</p>	<ul style="list-style-type: none"> • Aims to reduce MMR by 30% in 2001 through comprehensive quality RH services • Aims to reduce IMR by 30% through accelerated reduction in the neo-natal component of IMR • Interventions included: establishing clinical guidelines, adopting Baby-Mother Package, creating of traditional birth attendant network, strengthening referral system, improving forecasting of high-risk obstetric events, and producing more midwives, etc. No mention of private sector role.
<p>Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2013)</p>	<ul style="list-style-type: none"> • In the Roadmap’s Foreword, the President of Uganda admonishes all stakeholders, including the private sector, to use the Roadmap to achieve national goals of reducing maternal and neonatal deaths • One of the strategies– among many – are partnerships that promote coordination and joint programming to improve collaboration, maximize resources and avoid duplication. • Partnerships are defined narrowly to be corporate responsibility with private companies, encouraging them to subsidize government services or to “undertake social responsibilities in health” such as fundraising activities and private donations for the Road Map • Other forms of partnership include: (i) partnership with media, (ii) regular meetings with stakeholders, and (iii) provide TA and support professional associations in MCH areas.
<p>DRAFT: Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Sharpened Plan for Uganda (2016)</p>	<ul style="list-style-type: none"> • The plan is aligned with the Health Sector Development Plan 2014/15-2019/20 • In addition to strategies outlined in the Roadmap, the plan further prioritizes investments in adolescent SRH component, civil registration and vital statistics, and framework to monitor RMNCAH results. • The plan also costs the strategies and proposes the medium-term investment needed, in addition to an increase in operational expenses, to ensure that the required human resources, infrastructure, inputs and governance structures can deliver essential interventions. • The plan does not include references to PNFP or PFP role in achieving reductions in maternal and neonatal mortality and solely focuses on investments in public services.
<p>Health Systems Development: Maternal Health Review</p>	<ul style="list-style-type: none"> • The review acknowledges that in order to expand maternal health services, the government will need to engage the private sector. • The NHP II and PPPH Policy provide a framework by which the government can partner with the private sector • Strengthening collaboration and partnership with the private sector is an important principal in the NHP to help strengthen national health system and to maximize attainment of national health goals
<p>Health Sector Development Plan (HSDP) II 2015/16 – 2019/20</p>	<ul style="list-style-type: none"> • The HSDP II prioritizes reduction of maternal, child and newborn mortality. • The HSDP II acknowledges that poor results are due not to lack of appropriate policies but rather inadequate implementation of the existing polices and plans.

In the health sector, the MoH has put into place a number of policies with implications for maternal services. The NHP II sets maternal and reproductive health as a priority area and MCH is identified as a key element of the minimum health package. The elimination of user fees at public facilities in 2001 was another effort to increase mother’s access to health services by removing the economic barrier.

The National Safe Motherhood Program (SMP-1999) is the foundation of Uganda’s strategy to achieve significant reductions in maternal, neonatal and child mortality. Several changes occurred with the introduction of SMP Programme such as: establishing comprehensive training and curricula to expand and integrate midwifery, public health and clinical nursing skills; updating, standardizing and disseminating clinical guidelines for maternal/reproductive healthcare; instituting maternal death audits to raise provider awareness and encourage facility-level improvements towards better maternal health care; and involving communities to identify high risk pregnancies and prepare for emergency interventions. It is interesting to note that now, SMP only focused on public delivery of maternal services.

With a focus on achieving its MDG goals in maternal and child health, the Ugandan MoH updated the SMP in 2013 and drafted the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda. A review of the Roadmap shows that the government encourages all stakeholders in society, including the private sector, to work together to reduce maternal and neonatal deaths. However, the Roadmap offers few concrete recommendations on how to leverage private sector resources, except for corporate responsibility with private companies to subsidize government services and/or raise funds to donate to government programs.

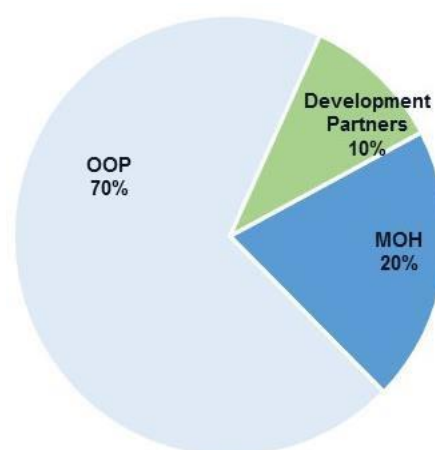
Currently, the MoH is developing the Sharpened Plan/Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) with funds and technical assistance from RMNCAH partners in Uganda. The draft plan - *RMNCAH Sharpened Plan for Uganda* - aims to accelerate the reduction of maternal mortality as targeted in the HSDP 2015-2020. Overall, the analysis assumes that only the public sector delivers and responds to the country’s RMNCAH challenges. In its analysis, the draft plan does not include other stakeholders’ contribution to maternal and child health services, particularly PNFs, NGOs and PHPs.

6.3.3 Financing of Maternal Health Services

Inadequate Resources for Maternal and Reproductive Health. There are three principal sources of financing for maternal health services: (i) MoH funds, (ii) donor funds and (iii) OOP expenses. The 2011/2012 NHA report states that UGX 566,404 billion were spent on maternal and reproductive health, which is approximately the same level from the previous year. Figure 6.18 shows the principal source of financing for RH services is OOP by individual households (70%). Public funds account for 20% followed by donor aid at 10%.

Women bear the financial burden of paying for their maternity services. Individuals pay less for FP and other RH conditions (less than 1% of OOP spending) compared to maternity (59%) and perinatal services (41%). Further, development partners are the principal funders for family planning and other RH conditions (Table 6.4).

Figure 6.18 Source of Expenditure for M/RH Services



Source: NHA 2011/12

Table 6.4 THE on Maternal and Reproductive Health Services

Type of RH Service	Public	Private	Other Private	Donors	Total
Maternal Health	60,192	230,281	-	15,955	306,428
Peri-natal	21,876	161,289	-	1,465	184,630
Family Planning	16,575	753	-	21,312	38,640
Other RH conditions	15,832	774	-	20,100	36,706
Total (%)	114,475 (20%)	381,754 (67%)	11,343 (2%)	58,832 (10%)	566,404 (100%)

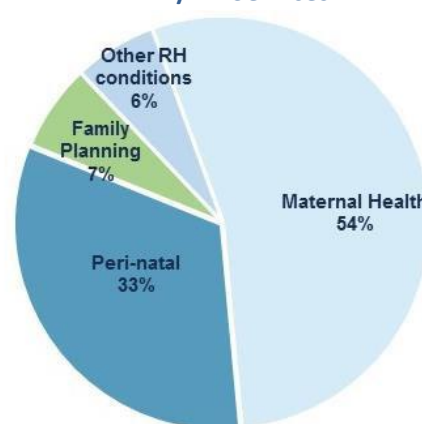
Source: NHA 2011/2012 Table 8.6

According to the NHA 2011/12, more than half of all expenditures (54%) were spent on maternal health services (Figure 6.19), while one third (33%) was expended on peri-natal care. Family planning and other RH conditions received the least funds -7% and 6% respectively.

To put the amount of resources spent on RH in perspective, government’s health expenditure in 2011/12 was three times more on HIV/AIDS (37.5%) than on RH services (12%).

Bringing More Resources to Maternal and Reproductive Health. To help remove economic barriers to maternity care, several donors have earmarked funds specifically for maternal and reproductive health programs (see Table 6.6).

Figure 6.19 Distribution of Expenditure for M/RH Services



Source: NHA 2011/12

Table 6.6 Summary of Donor Projects Supporting Maternal/Reproductive Health Programs

Program	Duration	Amount	Technical / Geographic Focus	Implementing Partner
World Bank Reproductive Health Voucher Project	5 years	\$13.5m	<ul style="list-style-type: none"> 4 ANC visits Facility delivery Post-natal including post-partum IUD Geographic scope: South Western and East Central Uganda 	Marie Stopes Uganda
USAID Maternal Health Voucher Program	5 years	\$24m	<ul style="list-style-type: none"> Service package: 4 ANC visits, Facility delivery, 1 post-natal visit for normal birth and 2 post-natal visits for C-section, EMTCT, Post-partum FP Geographic scope: Far East & North Uganda 	Abt Associates
Global Financing Facility	3-5 years	\$30 m	To be determined	To be determined

The two RH voucher programs will actively include both PNFP and PHPs providers but the key informants were not clear on how these sectors will implemented (e.g. claims process, payment terms, etc.). The PSA Team examined the voucher design program, its benefit package and reimbursement levels to determine if the programs are complementary and will not distort markets (e.g. one may pay private providers at a higher rate even though they deliver the same benefit package).

As a result, the main conclusion about these programs is that they provide much needed financial resources to decrease OOP costs. The Global Financing Facility (GFF) – a multi donor initiative that also includes the World Bank and USAID – MoH is in the process of finalizing the RMNCAH investment case to leverage funds from the GFF, World Bank and other partners to strengthen the health systems delivering maternal, neo-natal, child and adolescent health. A preliminary review of the draft RMNCAH investment case revealed no plans to work with the private health sector. GFF is in current discussion with the Uganda World Bank Team and the MoH to revise the investment case to include private sector opportunities.

6.3.4 Public-Private Mix of Maternal and Reproductive Health Services

Overall Supply of Maternal Health Services. As the 2007 SPA shows, just over seventy percent (71%) of all – public and private – facilities nationwide provide ANC services; 53% offer normal delivery services and only 5% can perform Caesarean sections. There are regional disparities in maternal service provision; Kampala, Central and East Central have the most health facilities providing a range of maternal health services while Northeast and Eastern Regions have the least (see Table 6.7).

Table 6.7 Percentage of Facilities with Select Maternal Health Services

Region	Ante-natal Care	Normal Delivery	C- Section	Emergency Transportation	Post-natal or Post-partum Care
Central	93	65	5	41	39
Kampala	76	63	26	69	67
East Central	72	58	4	51	31
Eastern	66	52	7	29	19
Northeast	51	46	4	46	33
North Central	67	60	6	80	39
West Nile	78	56	5	85	34
South West	61	39	4	38	27
Overall	71	53	5	47	31

Source: USPA Policy Briefs 2007

Source of ANC Services. According to 2015 statistics from the national DHIS 2, the majority of women (83%) receive ANC care from a public facility. Another 17% seek care in a private health facility, specifically from NGO (1%), PNFP (14%) and PFP (2%) (see Figure 6.20). Although attendance in ANC services is almost universal, there is still room for improvement, because women start their ANC visits late (median gestation period at first ANC is 5.1) and few (48%) complete the four recommended visits (UDHS 2011).

Location of ANC Services. Data from DHIS 2 also showed that the public sector delivers the majority (79%) ANC services in urban areas compared to 19% by private providers (both PNFP and PHP). The public sector is also the largest provider of rural ANC services: 88% compared to 9% by private providers (see Figure 6.21).

Figure 6.20 ANC Services by Provider

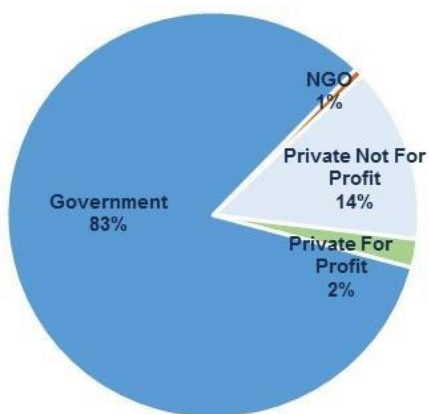
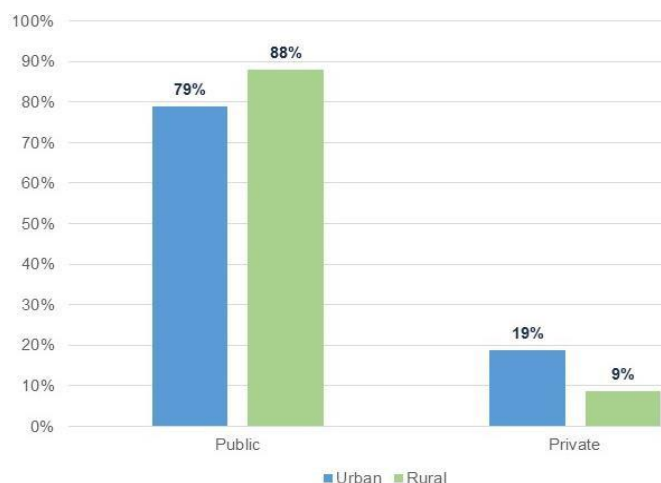


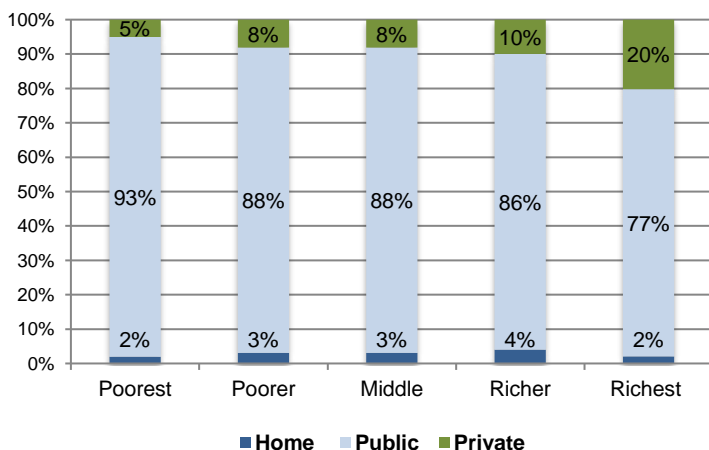
Figure 6.21 Location of ANC Services by Provider



Source: DHIS 2 Jan-Dec 2015

Income Group ANC Health Seeking Behavior. The public sector is the principal service provider for ANC visits across all income groups (Figure 6.22). Almost all of the lowest two quintiles receive free ANC visits in a public facility (93% for the poorest and 88% for the poorer quintiles). However, the public sector is subsidizing a significant percentage (10% of richer and 20% of richest) of women who can afford to pay for ANC visits. There may be opportunity to redirect the women who can afford to pay to PNFs and/or PHPs depending on their income level thereby freeing up scarce public resources that could be used to help decongest public maternity services. However, such a policy would need to be examined very carefully including any potential unwanted consequences. This could be a double-edged sword, e.g. further increasing the inequities through creating a parallel system for the rich and having little to no resources going into the system used by the poor.

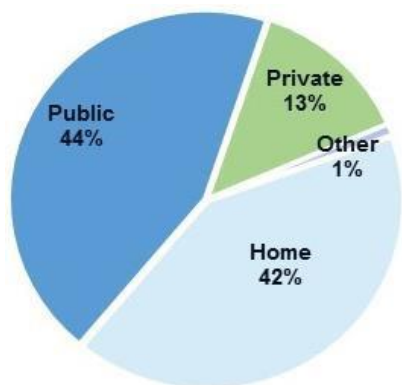
Figure 6.22 ANC Provider by Income Quintile



Source: UDHS 2011

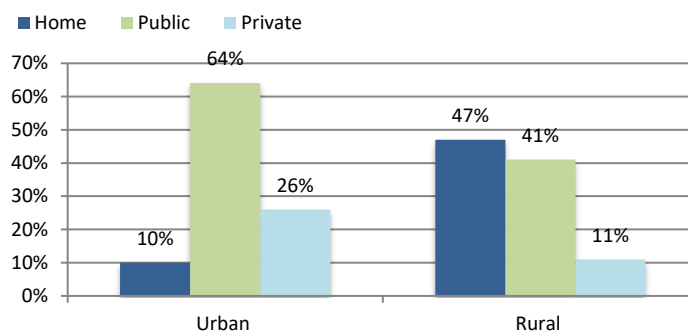
Source of Delivery Services. Figure 6.23 indicates where women deliver their babies. The majority of mothers (44%) deliver in a public facility. A significant proportion (42%) still delivers at home with unskilled attendants, while a small percentage (13%) deliver in private – either PNFP or PFP – health facilities. Figure 6.24 shows where women deliver by geographic location. In urban areas 10% of women still deliver at home but 63% deliver in a public facility and 26% in a private hospital or clinic. Clearly, the majority of home deliveries occur in rural areas – almost half (47%). Of those who deliver in a facility, most rural mothers deliver in a public one (41%), while a small percentage (11%) delivers in a private hospital or clinic.

Figure 6.23 Public-Private Mix of Delivery Services



Source: UDHS 2011

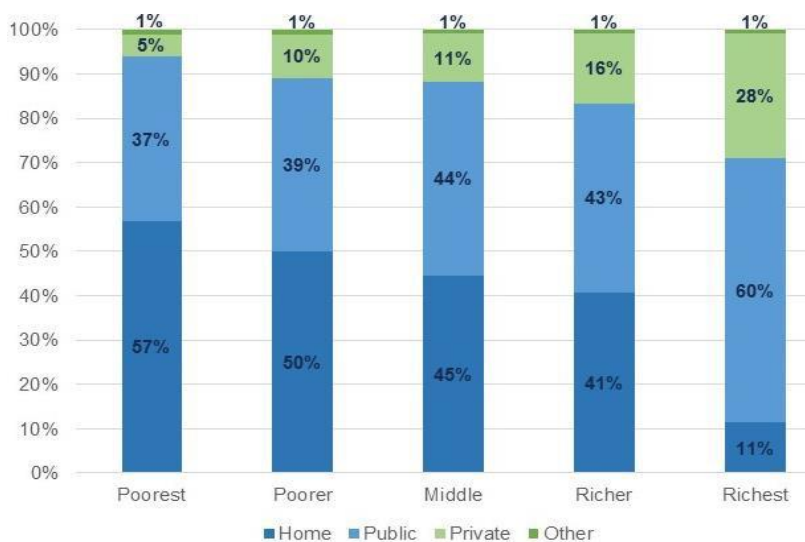
Figure 6.24 Location of Delivery Services by Provider



Source: UDHS 2011

Delivery Location by Income Group. The majority of poorest and poorer women deliver at home; 57% and 50% respectively, and even a significant proportion of middle-income women deliver at home (45%). The persistently high levels of home deliveries, particularly among the lowest income quintiles, underscores the urgent need to focus efforts on bringing these women into the formal health system to deliver their next child. Of the lower income groups, the public sector is the most important provider - 37% for poorest and 39% for poorer women. It is interesting to note that a small percentage of the poorest and poorer – 5% and 10% respectively – deliver in private facilities, which are mostly PNFP owned.

Figure 6.25 Delivery Provider by Income Quintile



Source: UDHS 2011

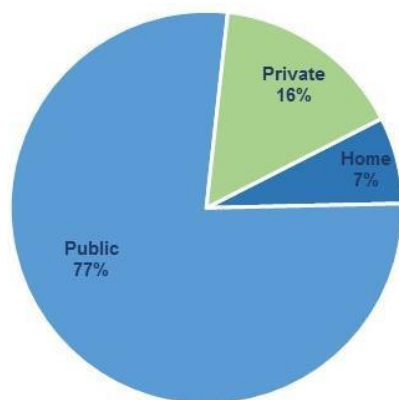
As expected, a growing number of women in the top three income groups deliver in a private facility, 11% for middle-income, 16% for richer, and 28% for the richest although the public sector is still the most important service providers for all three of these income groups: 40%, 43% and 60% respectively. The public sector is subsidizing those income groups that have the greatest ability to pay for their delivery in a PNFP or PHP facility.

Once again, directing women who can afford to pay to a private facility could free up much needed public resources to focus on the poorest income groups. Alternatively, the government can devise ways of keeping them in the same system, improving quality, and subsidizing payments for the poor, while those who can afford pick up more of the costs.

Post-natal Care. Follow-up visits after a delivery are critical for the survival and wellbeing of both the mother and child, because 60% of maternal mortality occurs in the post-natal period (MoH, 2016). Yet very few (33%) women who deliver attend a post-partum visit (UDHS, 2011). Cost and convenience as well as the fact that majority of deliveries happen at home are key reasons why a mother does not return to a health facility. Figure 6.27 shows that of the women who do attend a post-natal visit, three quarters (77%) go to a public facility while only 16% seek care in a private facility. A small proportion (7%) receives post-natal care at home.

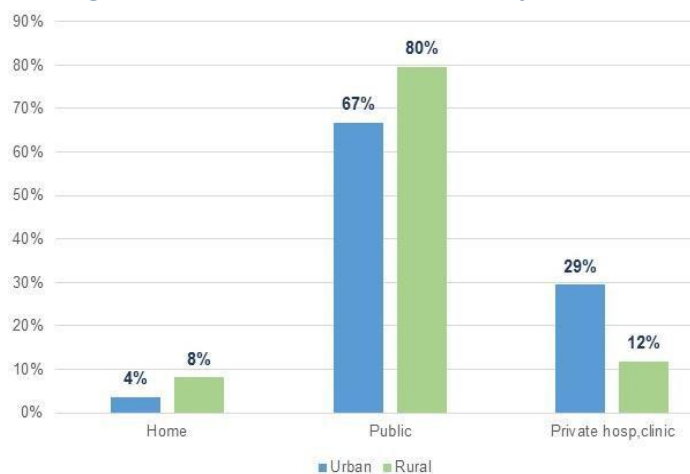
Of the women who deliver in an urban facility, 67% go to public facilities while 29% go to private ones. The proportion of rural mothers receiving PNC in public facilities is even greater – 80%. The percentage of rural mothers who seek a post-natal visit in a private hospital or clinic drops is only 12%.

Figure 6.26 Public-Private Mix of PNC Services



Source: UDHS 2011

Figure 6.27 Location of PNC Service by Provider

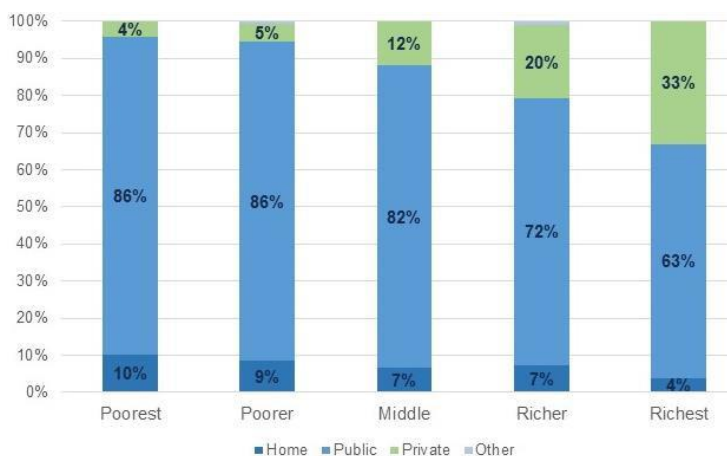


Source: UDHS 2011

One observes a similar trend as noted in delivery services in the type of provider by income group for PNC (see Figure 6.28). The public sector is the prominent provider among all income groups, including those who can afford to pay (e.g. middle, richer and richest). The private sector serves all income groups, including the poor and poorest albeit in small numbers - 4% and 5% respectively.

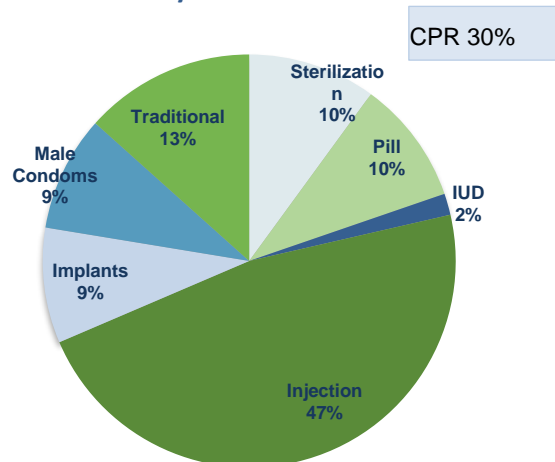
The public sector subsidizes a significant proportion of middle-income (82%), richer (72%) and richest (63%) mothers when these funds could be redirected to serve the lower income groups who are the most likely *not* to seek post-natal care.

Figure 6.28 Type of Post-Natal Care by Provider by Income Quintile



Source: UDHS 2011

Figure 6.29 FP Method Mix among Currently Married Women

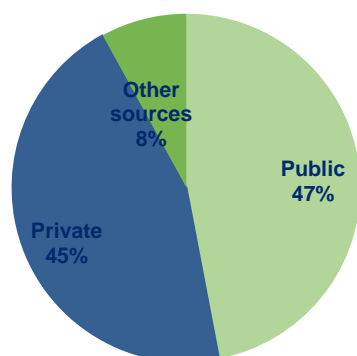


Source: UDHS 2011

Family Planning. Contraceptive prevalence is still very low in Uganda compared to other SSA countries. Only 30% of women of reproductive age use some form of contraceptive, of which 26% are modern methods. Uganda women prefer injectables (47%), followed by the pill (10%) and sterilization/implants (9% each). IUDs are the least popular - IUDs (3%). The type of method preference has implication for the private sector. Medical dependent methods such as LARC are more difficult to deliver through private channels, such as private pharmacies and drug shops without modifications in the scope of practice and robust quality assurance measures to ensure safe delivery and management of contraindications.

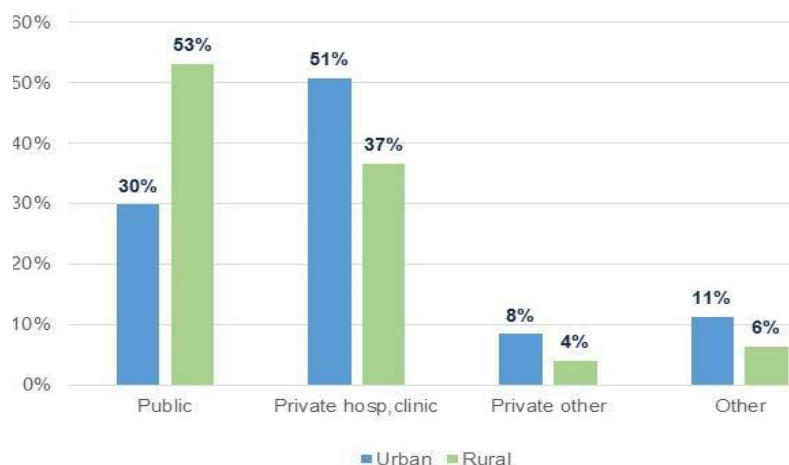
In Uganda FP is a different market compared to HIV/AIDS and maternal health. Although the public sector is the major source of modern contraceptive methods in Uganda - 47% women source their FP methods from public facilities - the private sector plays a significant role in delivering FP methods with 45% women getting their supplies from this sector (Figure 6.30). Within the public sector, women receive their methods mainly from government hospitals (14%) and health centers (29%), while in the private sector; they get them mainly from a private hospital or private clinic (40%).

Figure 6.30 Public-Private Source of FP Methods



Source: UDHS 2011

Figure 6.31 Location of FP Source by Provider



Source: UDHS 2011

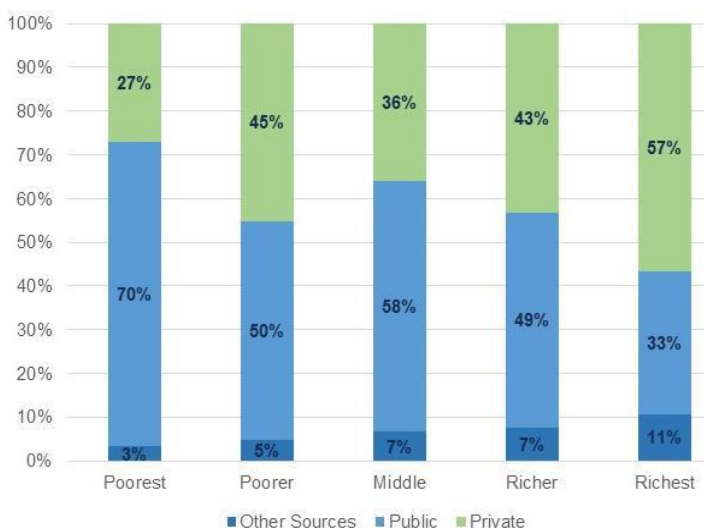
Urban women rely less on public facilities for their source of FP methods (30%) compared to private hospitals and clinics (51%) and other private sources (8%) such as pharmacies. Conversely, the majority of rural women obtain their FP methods at a public facility (53%), but a considerable proportion get their FP method at a private hospital or clinic and private pharmacy – 37% and 8% respectively.

A breakdown of where women source their FP method by public and private providers reveals a clear-cut trend in provider preference.

- Female sterilizations and implants are largely performed in the public sector (79% and 85% respectively),
- Conversely, injections are mostly sourced from the private sector – 60% compared to 39% from the public sector.
- Pills and condoms are sourced from both public and sectors equally (46% compared to 52% for pills and 46% compared to 45% for male condoms)

More specifically, one quarter of pill users (25%) use the social market brand Pilplan while four in ten (38%) use Microgynon: these brands are available through private channels. Condoms are widely available in different locations, but the majority are sold in shops (33%). More than half of condom users (54%) use the socially marketed brands Engabu, Lifeguard, or Trust and about one third (29%) use Protector. It is important to note that 43% of FP users discontinue their method within twelve months of starting its use, mostly due to fear of side effects or health concerns (UDHS 2011).

Figure 6.32 Source of FP Method by Income Quintile



Source: UDHS 2011

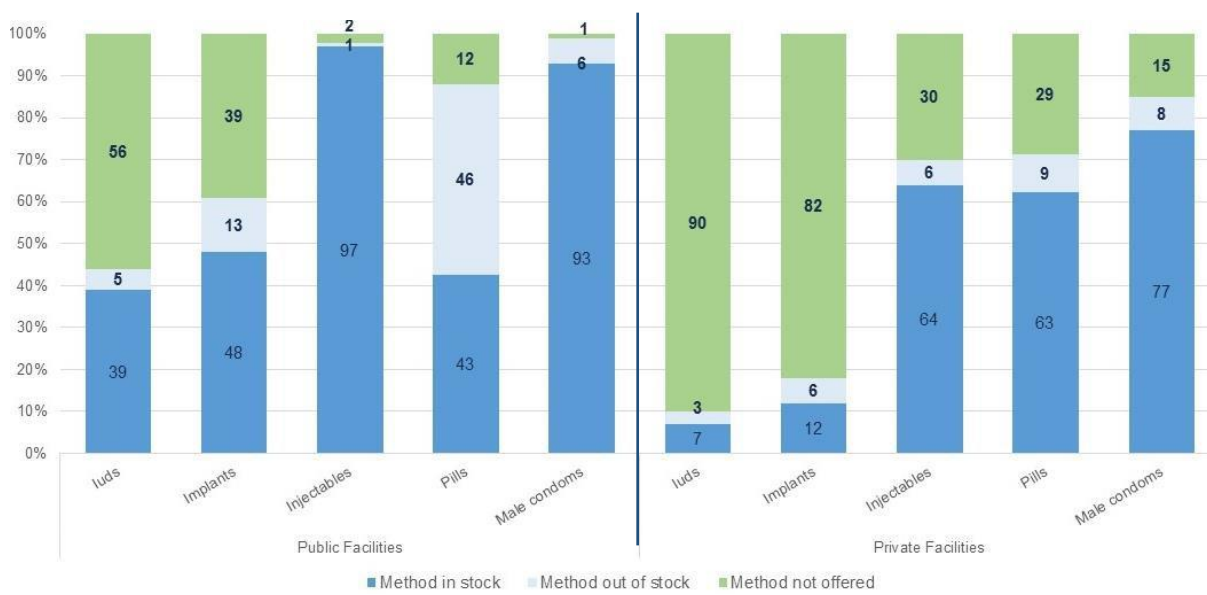
A significant proportion (46%) of public facilities do not have pills in stocks. There are fewer public facilities experiencing stock-outs for IUDs and implants - 5% and 13% respectively and they have constant supplies of injectables (almost 100%) and condoms (93%).

Unlike the public sector, most private facilities (63%) have a steady stock of pills, but they do not offer Ugandan women’s preferred methods – 82% do not offer implants and 30% do not offer injectables (Figure 6.33). This is a missed opportunity for delivering FP methods.

The market is better segmented by income groups for FP compared to HIV/AIDS and maternal health service and products. As Figure 6.32 shows, the majority of women in the poorest (70%) and poorer (50%) quintiles get their FP method free from a public facility. Wealthier women rely more on the private sector for their FP method. Yet a large percentage of the poorest (27%) and poorer women (45%) still get their FP method from a private facility, primarily because of the constant stock-outs in public facilities.

A significant proportion (46%) of public facilities do not have pills in stocks. There are fewer public facilities experiencing

Figure 6.33 FP Methods Availability by Provider



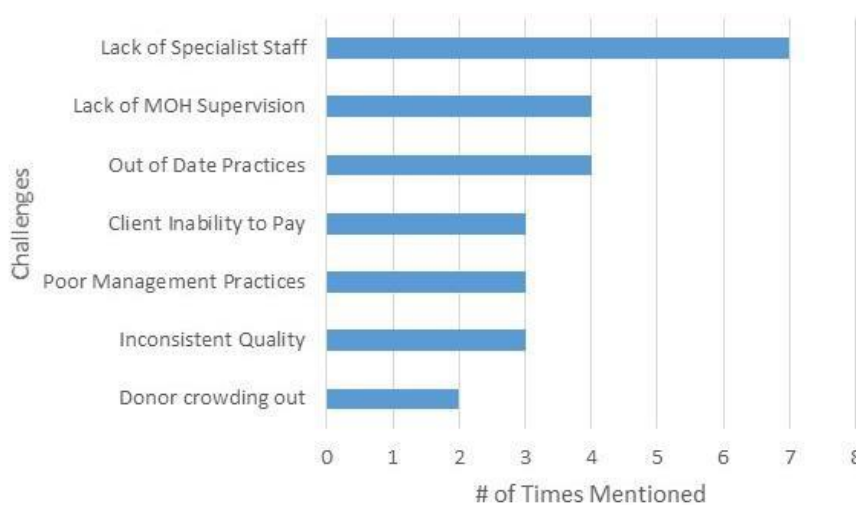
Source: DHIS 2 Jan-Dec 2015

6.3.5 Key Findings on PHPs Role in Maternal and Reproductive Health Services

The MoH policy is to collaborate with non-government providers to deliver maternal health services. The MoH has primarily focused its partnership with FBO hospitals and provided financial and in-kind support through conditional grants. The MoH collaboration with PHPs delivering maternal and reproductive health services is very different from its working relationship with PHPs delivering HIV/AIDS services. Through PEPFAR funds, the MoH has been able to scale up its collaboration with the private health sector to accredit private facilities and regularly monitor their quality of HIV/AIDS care. As a result, the majority (80%) of PHPs collaborate with the MoH to deliver HIV/AIDS services. In contrast, the PHPs delivering maternal and RH services operate mostly independently of the public health system.

However, both PHP and PNFP healthcare businesses face similar challenges. Figure 6.36 shows the challenges identified by maternal and RH stakeholders. They are discussed in detail below.

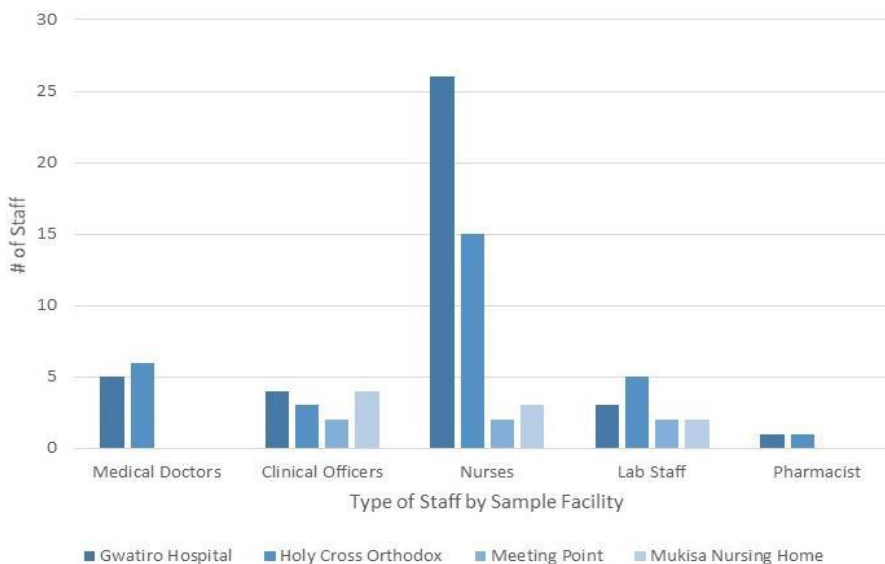
Figure 6.36 Challenges Faced by Private Health Facilities



Source: PSA Stakeholder interviews, 2016

Although staffed with qualified providers, PHPs struggles to recruit and retain them. Key informant interviews affirmed that most PPs facilities delivering maternal health services are small and medium-sized entities. Given their size, they are mostly staffed with one to two nurses or clinical officers. The larger facilities, such

Figure 6.35 Staffing Patterns in PHP Facilities – A Case Study of 4 PHPs



Source: PSA Stakeholder interviews, 2016

as small hospitals or nursing homes, have full-time or part-time physicians as staff (See Figure 6.37). Nevertheless, the key challenge is lack of access to specialist staff in case of complicated delivery and/or obstetric emergency. As the HRH section shows, PHP healthcare businesses experience the most difficulty in recruiting and retaining staff compared to the public and PNFP sectors. Although the working conditions are better in higher level PHPs in terms of quality of facilities, availability of equipment and accessibility of medicines, PHP

business cannot compete with public salaries and benefits at the same level (see Section 9).

Quality of maternal and reproductive health services varies widely among PHPs.⁴² Health facilities in both the public and private sector are under-equipped and under-financed to provide quality services to women and newborns. Up to 35% of health facilities, lack basic supplies for ANC visits, and less than 30% perform needed diagnostics that can alert providers of potential complications. Three-quarters of all facilities offer requisite ANC medicines.

“MoH rarely comes. If they do, they give limited support to data; they look at data collection tools. We never get to know when the guidelines change.”
PHP respondent, Kampala

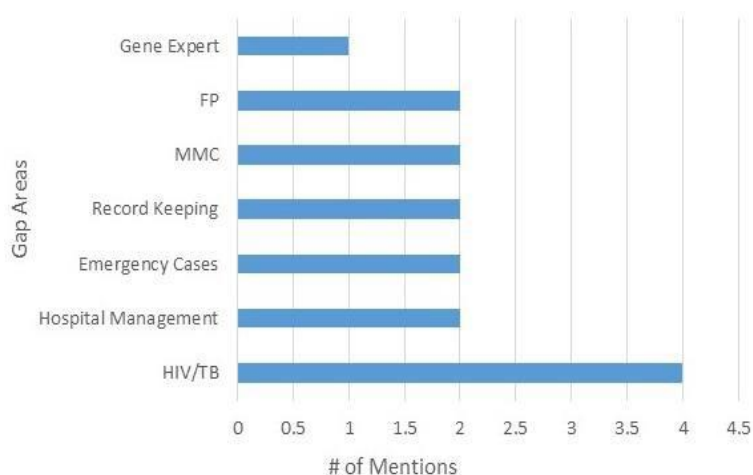
Normal delivery services are available in 53% of all facilities. Only one-half of these facilities have a trained provider on site 24 hours a day. Only one third (33%) have all the necessary supplies to support routine delivery. Even fewer – 11% – have additional medicines to manage obstetric complications. Health facilities also have limited capacity to provide emergency support for newborns. On average, only 45% that provide delivery services have an external health source and perform potentially harmful practices (e.g. full immersion bath). Poor transport infrastructure is a hindrance for service uptake; with ambulance services being largely absent, making hospitals less responsive to the needs of maternal and newborn emergencies. Almost all of the private health facilities interviewed for the PSA reported having little or no quality checks or support from the MoH. The few that received a visit stated the MoH staff came only once and rarely twice a year. Lack of supervision and regular interaction with MoH has reportedly led to poor patient management and low quality of services as well as outdated practices still being in place in many of these facilities.

⁴² All data is taken from Uganda Service Provision Assessment, 2011. <http://dhsprogram.com/pubs/pdf/PB3/PB3.pdf>

PHPs experience skill gaps in key areas such as FP methods and counseling.

Most of the private providers interviewed said they lacked access to clinical training and training updates. The majority of stakeholders indicated that training in HIV /TB care was the biggest gap followed by counseling in FP, SMC (Figure 6.36). Strengthening business skills, such as hospitals management, record keeping and financial administration, were also noted as a significant gap. Many of the stakeholders observed that they were not invited to MoH or donor sponsored trainings and when they do participate in these trainings, PHP staff experience challenges, such as the training content is too heavy or extends over too many days. Also, lack of staffing to cover for those who are away for training as well as “scraping” for per diem so staff can attend the training are common reasons for low participation in these trainings. A few of the stakeholders suggested a modular approach to training in order to balance work related demands and the need to keep oneself updated on the latest medical advances.

Figure 6.36 Training Gaps Highlighted by PHPS



Poor clients rely on quack health workers because they cannot afford formal private maternal and RH services. The MoH has an inadequate and weak regulatory system that regulates and closes unlicensed health centers/clinics administering substandard medicines. A large proportion of Ugandans, especially the poor, seek healthcare from unqualified and “traditional and spiritual” healers because they cannot afford health services in the public sector or are faced with drug stock-outs and non-functioning laboratory equipment forcing them to seek these services in the private sector. In addition, the high cost of accessing services for pregnant women (in terms of both time and fees for maternal services) prompts women to deliver at home instead of in a health facility.⁴³

Many PHPs interviewed, particularly the small facilities, offer services at highly reduced fees because they recognize many of the clients cannot afford to pay. In the case of the larger facilities, they often exempt or let the woman pay what she can afford, thus showing concern for equity among those engaged in PHP service delivery and countering the misconception that all PHPs are only concerned about profits. Incentives could be explored for those PHPs willing to offer services to disadvantaged people at a reduced fee or even free with some benefits they receive from the government in exchange. Several interviewees also stated that a NHIS would greatly relieve this economic barrier as well as help them make ends meet. Several referred to the RBF program as a model and complained that they were ineligible to participate because they are not located in the priority districts despite the fact that they also see many poor mothers.

PHPs providers are more efficient yet experience under capacity compared to public M/RH services. Private health services have proved to be more efficient than public ones; a study on Maternal Health Services showed that NGO/FBO providers delivered, on average 68 babies per year compared to 38 babies delivered in public health facilities (Levin et al, 1999). The problems of short disappearances from duty, short working hours and dual practice of MoH staff in both public and private practice, contribute to low staff productivity in government facilities. The same study concluded that these numbers (of deliveries) are significantly below potential capacity. Another crosscutting problem is poor planning of public and private HRH.

⁴³ Ministry of Finance, Planning and Economic Development. *Learning from the Poor: Uganda Participatory Poverty Assessment*. 2000.

In some cases, there is a surplus of public midwives in relation to the maternity workload (Levin et al, 1999), while in others, such as the two maternity hospitals in Kampala, there is an insufficient number of public sector midwives, yet in the same catchment area, there are private – both FBO and NGO – midwives that are underutilized and have demonstrated capacity to deliver affordable, quality maternity care (see Box 6.8 and 6.9). This may need to rationalize the referral system using facilities in a network and using incentives to promote. This underscores the need efficiencies in service delivery.

Box 6.8 Private Midwife Network



In 2008, PACE established a social franchise network of clinics named ProFam. There are 200 clinics in the franchise, of which 85% are private-for-profit. They are located in 54 districts in all five regions of the country. A ProFam clinic is licensed by the MoH and owned and managed by a certified midwife, clinical officer or a medical doctor. In addition to the owner/manager, a typical ProFam clinic has 3 staff comprised of nurses, midwives, clinical officers, and nursing assistants. ProFam's goal is to reduce maternal mortality by providing high-quality, affordable, integrated family planning and comprehensive maternal health services. The ProFam providers offer a wide range of reproductive health services such as long-acting reversible contraceptives, short-term methods and cervical cancer screening). On average, a ProFam clinic will attend to 11 deliveries, 41 ANC visits, offers 40 women long-term family planning methods and tests 25 women for cervical cancer.

PACE invested in strengthening ProFam's clinical capacity, demonstrating that with guidance and support, private providers can adhere to MoH service provision protocol in both family planning as well as maternal health, including labor and delivery. An evaluation of ProFam providers showed that 81% complied with PSI global standards, 75% had the required equipment and supplies needed, and 74% adhered to infection prevention practices. The evaluation showed that between 2013 and 2015, the number of pregnant women coming back for 4th ANC visits increased greatly from 36% to 57%.

The majority of clients (71.5%) felt that the ProFam provider offered high quality care, delivered good customer services, and that the services were convenient (e.g. location, hours).

Box 6.9 Overcrowding in Public Sector Maternity Wards

Mulago Hospital, the national referral hospital now records about 110 deliveries a day – three times more than it is intended for, says one doctor, who has worked at this hospital for 22 years. “There is a lot of overcrowding in this hospital,” he continues. He shares the story of a recent patient, who lives in a Kampala suburb about five kilometres from Mulago Hospital. “Since she could not afford to deliver her baby in a nearby private clinic more convenient to where she lives, she opted to go to Mulago. She checked in at 2 am and successfully delivered her baby by 8 am. However, I found her lying outside the ward's veranda because she had to create space for other expectant mothers. She was not allowed decent rest on a bed in the ward.”

Another doctor, a medical intern, explained that the hospital has tried to cope by making modifications to create more ward space but even then some mothers are asked to sleep on the floor or even to share a mattress with another mother. “A room designed to accommodate six beds now has 18, which is still not enough for the hundreds of patients we receive each day.”

“Government funding is part of the problem,” share both doctors. They suggested that formal work agreements between the public sector and the private providers to relieve some of the stress on public facilities or to establish a national health insurance to remove economic barriers allowing mothers choice in providers are ways that could reduce the overcrowding in Mulago.

Donor programs using market incentives do not necessarily follow community demand and private provider supply. Donors' interests limit what and where private facilities and implementing partners focus on as opposed to the interests of the community. Stakeholders often referred to the mismatch between the World Bank and USAID maternal health projects and the supply of PHPs offering maternal health services.

Moreover, as the Mulago example illustrates in Box 6.9, there is still need to remove economic barriers for women living in peri-urban areas in order to decongest public facilities yet none of the voucher programs address this challenge.

6.3.6 Public-Private Interactions in Maternal Reproductive Health Sub-Sector

As mentioned before, private providers delivering HIV/AIDS services in particular PNFPs, have a close working relationship with the MoH. Although there is a greater focus on PNFPs, the MoH is still open and willing to work with PHPs. In the case of the maternal and RH health services, However, PNFP respondents perceived that the government more open to PNFPs compared to PHPs with very little room for PHPs.

Private Practitioners confirmed this finding and reported that the MoH and external donor funders are generally “closed” to the participation of the private sector in maternal and RH service delivery. However, the PNFPs also complain that although there may be MoH commitments to engage the PNFPs in planning and service delivery, in terms of operationalization, and particularly financing, these pledges are often vague or inadequate (see Section 4). Some stakeholders interviewed stated that there are private sector champions in the public sector, but these are rare and affiliated with certain health areas, such as HIV/AIDS. Indeed, interviews with the maternal and RH Department demonstrated their reluctance to work with PHPs. PHPs expressed hope that if the NHIS materializes, it may open lines of communication and engagement with the public sector. When asked their opinions on representation of the private sector, all PHP respondents wanted to see a unified PHP representative to engage with government. Many interviewed supported the excellent work the PNFP medical bureaus performed to address fragmentation and standardize quality. Some also cited other associations, such as UPNMA and UHF as possible candidates to represent PHPs provider interest with the government. While no PHP respondents had formal agreements with the MoH or government, almost all stated that they would welcome greater partnership and engagement that is more formal. Service contracts, future NHIS contracts, grants, vouchers, subsidies and tax breaks were encouraged by most respondents. PHPs particularly preferred subsidies for equipment (especially diagnostic equipment) or drugs, as they often perform lab functions and other services for public sector referrals.

6.3.7 Recommendations to Leverage PHPs in MCH Services

Stakeholder interviews with PHPs and MoH officials prioritized the specific areas elaborated below as potential opportunities in which to integrate private providers (PNFP and PHPs alike) to compliment MoH efforts to improve mother and child health conditions in Uganda.

1. **Create incentives to organize PHPs.** The MoH can play an instrumental role in structuring private delivery of maternal and RH services through incentives such as service contracts, vouchers, RBF that require PHPs join an umbrella organization such as UPNMA and/or network like medical bureaus, MSI or PSI in order to participate in these programs. New Zealand (and Australia) successfully reorganized all their general practitioners – all private providers - in less than five years by using a dual strategy on service contracts and membership requirements (see Box 6.10).

In addition to creating market incentives, MoH and development partners can provide funds and technical assistance to strengthen these respective networks. Although the medical bureaus are a well-established network of FBO service providers, they still need funds to add additional staff, and build or extend their quality systems. Moreover, they expressed a need to strengthen their financial management and administration capacity. Other types of networks, like UPMA and the social franchises require funding to not only build up, but also to make their networks fully functional and sustainable. Another area of technical support includes assisting the networks to help their members become “voucher ready” so they can participate in the World Bank and USAID maternal health voucher programs.

Take Home Messages on Maternal and RH Services and the Private Sector

- The Uganda health sector still has many challenges to overcome to ensure safe motherhood despite multiple policies and strategies. The NHA clearly demonstrates that ***both the government and donors are not investing enough funds and technical assistance to address the shortcomings in maternal and RH services.***
- As a result, ***most of the financial burden has fallen on expectant mothers and their families***, as demonstrated by the high OOP cost for maternity services. FP, on the other hand, is highly subsidized in both the public and private sector and therefore, women pay less OOP for their FP method.
- The ***World Bank voucher program and Jinja RBF experience have demonstrated that the MoH can quickly expand MR/H service through existing PNFP and PHPs providers.*** Most PNFP and PHPs providers welcome the opportunity to increase their maternal and RH services through financing mechanism like vouchers, service contracts and NHIS but these policy tools are not widely used in Uganda.
- There is ***general consensus that PHP midwives offer a convenient and a possible strategy to decongest public facilities.*** Women prefer PHP providers because access is easier since they are often located in the expectant women's community, offer longer clinic hours and shorter waiting times, and are highly respected by the community for their services.
- ***Small private maternity wards offer quality services.*** They are staffed with a wide range of trained and licensed health professionals and in some cases; they have specialists who are able to care for emergency deliveries; and their facilities are modern, equipped and have consistent supply of needed medicines.
- ***The PSI and MSI experiences demonstrate that networks of solo practitioners can offer affordable, quality health services.*** Both networks have established systems in place to assure quality by providing regular training, donating supplies and medicines, and supervising network providers.

Box 6.10 Restructuring Primary Health Care in New Zealand

In 1996 the MoH combined 4 Regional Health Authorities into a single purchasing agency called the Health Funding Authority. The Primary Health Care Strategy, with the new funding mechanism, required all general practitioners to come together under Primary Health Operators (PHOs). The primary health care market was restructured to conform to the new policy approach. Initially general practitioners (GPs) operated as for-profit, independent owner-operators but under this new strategy, most joined a PHO in order to receive financial reimbursement for PHC services delivered.

The PHOs became the unit for performance monitoring as well as setting reimbursement fees linked to performance indicators. The PHOs reviewed and processed all individual GPs claims and assured they complied with national quality standards. Moreover, the PHOs were responsible for assuring each individual GP's quality of care. The PHOs had to report on a set of performance indicators each month to MOH headquarter staff and District Health Board's (DHBs). The DHBs success depended on how well the PHOs in their jurisdiction performed. As a result, all stakeholders – MOH staff, DHB management and private GPs, knew health targets were being closely monitored.

In monthly meetings with PHOs, DHB Planning and Funding teams reviewed health targets and funding as well as strategies on how DHB could support their PHOs. This improved communication between the DHB and the PHO and also emphasized regular reporting on health targets and what organizations were doing to improve PHC coverage.

(Source: Ashton et al., 2005)

- 2. Decongest maternity services at public hospitals by contracting private providers.** PNFPs already play a critical role in expanding maternal and RH services on behalf of the MoH. However, there is room for PHPs to expand their health services to “pull” public patients away from congested public facility maternity wards. KCCA has declared its interest in exploring service contracts with Profam providers. However, both the health authority and Profam need assistance on how to cost such a proposal, design the service contract, negotiate the terms of the agreement, and establish a monitoring system to ensure each partner plays their respective role. Several countries in the region, such as Tanzania and Malawi have experience in service level agreements that serve as a proto-type for Uganda. There is also experience in contracting private midwives under a national health insurance program in the Philippines (see Box 6.11).

Box 6.11 Contracting Private Midwives in the Philippines Care

To address the high, unmet need for public health services, the Department of Health (DOH) launched the Universal Health Care Program, also known as Kalusugan Pangkalahatan (KP). KP provides every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, and fairly financed through PhilHealth - the national health insurance fund. PhilHealth has created a system to accredit, empanel and reimburse private practice midwives (PPMs).

To expand the number of service providers, PhilHealth coordinates with the DOH to train PPMs to become eligible as a PhilHealth. The training is comprehensive and includes all FP methods, IUD insertion, pre-natal and delivery, and EmOC. The DOH also helps PPMs establish basic QA and reporting systems and conducts regular supportive supervision. Expectant mothers and their families receive a predefined set of health services at no cost. In exchange, PhilHealth reimburses the PPMs. PPM representatives are involved in negotiating the fees with PhilHealth. The program has become increasingly popular with mothers. The PPMs offer convenient hours, easily accessible location and no waiting time. In addition, they appreciate the customer service and perceived quality of care.

(Source: http://pdf.usaid.gov/pdf_docs/PA00K7F3.pdf)



3. **Support private pharmacies/drug shops to deliver FP methods.** There is growing country experience (e.g. Ghana with ORS, India for TB and Senegal and Vietnam for FP and other RH health products), on harnessing the infrastructure and access of private pharmacies and drug shops, particularly in rural and peri-urban areas for maternal and RH. Uganda could implement similar initiatives by establishing an accreditation process based on good prescribing practices and empower eligible private pharmacies and drug shops to offer a full range of FP methods including Depo at no cost to women.

Ghana private pharmacists delivering Depo



In the case of Kenya, the private drug shops formed a network under the umbrella of the Pharmacy Technicians Professional Association. To assist the private providers, the MoH donates products, supports raising awareness on the benefits of FP and the availability of quality methods at accredited facilities, and reimburses the provider for “dispensing” the FP method (See Pharmacy Section for more details).

4. **Establish/scale up FP mobile services to increase the use of modern FP methods.** MSI has a proven approach (20 countries) to scale FP outreach services successfully. Their standardized model establishes a FP mobile outreach team staffed with a clinician, counselor and driver who work with public health community health workers and volunteers to coordinate visits and maintain community health registries. The team visits each site on a regular schedule so that the community can plan on the visit. During the visit, the team offers IEC, temporary and LARC methods on the spot. These outreach programs have increased the number of new acceptors and increased use of modern methods. Moreover, the team has been able to manage side effects better, thereby increasing client satisfaction with their selected method. The model has been so successful with increasing FP use, that MSI is now integrating HIV/AIDS testing and counseling as well as ART compliance.
5. **Increase number of midwives.** Several stakeholders interviewed suggested that the MoH offer scholarship funds for students to become midwives with obligatory public service in underserved areas. The MoH would directly pay the private (in this case, PNFP) health training institutes for these scholarship students. In order to help retain these midwives in rural areas, other country programs have focused the recruitment of potential student from the under-served communities themselves. The student can then return to his/her community to perform their public service.

7. ESSENTIAL MEDICINES AND HEALTH SUPPLIES

The supply chain system for essential medicines and health supplies (EMHS) is one of the most studied in SSA (MoH/SURE, 2010). Although most of these analyses have focused on the public and PNFP supply chains, there is increasing evidence of private sector activities and their possible role in helping create a more efficient system that delivers essential drugs at an affordable price. In FY 2013/2014, almost half (49.5%) of public health units had monthly stock-outs of indicator medicines meaning patients had to look elsewhere for them, hence a heavy reliance on the private sector (National Pharmaceutical Sector Strategic Plan 2015/16-2019/20[NSSPP III]).



This section provides an overview of all the EMHS supply chains operating in the Ugandan pharmaceutical sub-sector. Given the wealth of information on the public supply chain, the PSA team focuses primarily on describing private sector activities in EMHS and the interactions (or lack thereof) between the public and private supply chains.

Table 7.1 summarizes key instruments and indicators for the pharmaceutical sector.

Table 7.1 Key Policy Documents and Indicators for Pharmaceutical Sector

Indicator	Description
Date of National Drug Policy	1993 (Updated 2002)
Date of Essential Drug List	2002 (Updated 2012)
Date of National Standard Treatment Guideline/Uganda Clinical Guidelines	2003 (Updated 2012)
GOU allocation to medicines	UGX 219 billion
Percent of MoH budget for medicines	17% (2015/16) ⁴⁵
Total per capita medicines expenditure	US \$ 2.4 ⁴⁶
Number of registered Pharmacists	985 (1: 50,000 people)

Sources: AHSPP 2014/15; NPSSP III 2015-2020;

7.1. Policy Environment

Since the early 2000s, the GOU has developed two comprehensive policies – the NHP I and II – that aim to increase access to essential medicines as part of the national effort to deliver the Uganda National Minimum Healthcare Package (UNMHCP). The focus on increased access to essential medicines and UNMHCP are part of the broader country strategy outlined in the NDP II and HSDP 2015/16-2019/20 and efforts to meet the SDGs.

⁴⁴ NPSSP III 2015-2020

⁴⁵ MoFPED, National Budget Framework Paper 2015/16

⁴⁶ NPSSP, 2015-2020/AHSPP 2014/15

Table 7.2 Policies with References to Private Pharmaceutical Sub-Sector

Legislation	References to Private Sector
Pharmacy and Drugs Act (1970)	<ul style="list-style-type: none"> • Bars the operation of pharmacies by non-pharmacist. “No person shall cause or permit any premises to be open to the public for the sale of drugs under the description “pharmacy”, “dispensary”, “chemist” or “drug store”, or any similar description, unless a pharmacist is on the premises and is supervising the activities carried on”. • Calls for at least four members of the Council to be pharmacists in active practice (does not explicitly mention whether public or private).
National Drug Policy and Authority Statute (1993)	<ul style="list-style-type: none"> • Guides regulation of the importation, production, distribution, marketing, exportation and use of pharmaceuticals in the public as well as in the private sector. • Promotes the rational use of drugs in both the public and private sector. • Indicates that membership of the committees on essential drugs and the national formulary should have representatives from the Uganda Private Medical Practitioners Association (UPMPA).
National Drug Policy (2002)	<ul style="list-style-type: none"> • Provides for medicine and health supplies distribution system for both the public and private sectors. Also assigns roles and responsibilities to different institutions to facilitate distribution throughout country. • Defines strategies to ensure supply, selling and distribution are regulated and to monitor manufacturing, whole and retail activities. • Calls for active partnerships between government and private providers to optimize use of available resources, knowledge and expertise in implementation of NDP. • Calls for collaboration with private sector, which is necessary to promote harmonization of the public and private drug distribution networks. • Encourages private sector to procure generic drugs so as to complement the public sector procurement system. • Promotes use of the Essential Drugs List for Uganda (EDLU) in the private sector. • Highlights the need to establish incentives to promote private sector involvement and investment in pharmaceutical services as well as local manufacture of medicines.
Public Procurement and Disposal of Public Assets Act (2003)	<ul style="list-style-type: none"> • Requires all NMS procurements to follow a competitive procurement process. JMS, UHMG and private entities are not subject to same processes.
Vote 116 (2009)	<ul style="list-style-type: none"> • Consolidates all financing for EMHS into a single pool, which is managed at the central level by MOFPED with NMS. Mandates NMS to procure all EMHS. • Does not allow public facilities to procure medicines from JMS or any other pre-qualified supplies if they experience shortages.
AHP Statute (Section 35) (1996)	<ul style="list-style-type: none"> • Created Vote 116 for medicine and health supplies to improve the financial base of NMS. Addressed the challenges associated with old system of credit line and sending medicine funds to districts and public hospitals.
National Health Policy II (2010)	<ul style="list-style-type: none"> • Encourages gradual reduction in donor dependency for EMHS • Strengthens regulations of pharmaceutical sector including setting prices for the private sector • Promotes regional and international collaboration on medicine regulation and bulk purchasing in line with East African Community initiatives • Integrates relevant aspects of private sector activities into the MoH pharmacy policy

Legislation	References to Private Sector
<p>National Pharmaceutical Sector Strategic Plan 2015/16-2019/20 (NPSSP III)</p>	<ul style="list-style-type: none"> • Expects both PNFP and PFP providers to become more central to the efforts to achieve UHC and ensure equitable access to medicines. Private actors will be engaged wherever possible to support interventions aimed at increasing the reach and quality of pharmaceutical services. Private sector engagement key objectives are to 1) promote public private partnerships in the pharmaceutical sector in order to address gaps in access to safe, efficacious and good quality EMHS, and 2) Engage the private sector in all aspects of policy implementation. • Coordinating bodies such as the religious medical bureaus, the Pharmaceutical Manufacturers Association, the Dispensers Association and PSU will provide useful entry points for effective engagement with the private sector. • Notes that the NDA has placed a lot of legislative and regulatory emphasis on the private sector. Due to the increased oversight, fewer facilities were licensed in 2013/14 compared to the preceding year. • Acknowledges information from PFP's s captured and aims to establish mechanism to integrate PFP health facilities into national pharmaceutical information system.
<p>National Medicines Policy (NMP) 2015</p>	<ul style="list-style-type: none"> • Identifies one of the key priority areas as to establish a functional integration within the public and private sectors. • Prices in private sector are, on average, 3-4 times higher than in the public and PNFP sectors, yet country does not have pricing policies or regulatory mechanisms. • Enactment of Industrial Properties Act (2013), which recognized and incorporated flexibilities in the multilateral Agreement on Trade-Related Aspects of Intellectual Property (TRIPS Agreement). • Declares MoH's intentions to proactively engage private sector participation in policy implementation.

7.1.1 Policy and Regulatory Framework

Uganda's medicine policy framework aims to ensure that medicine supplies are safe, effective, and of good quality and that they are available, accessible at all times, affordable and used appropriately).

The National Medicines Policy (NMP) 2015 established the institutional arrangements to undertake the policies and regulations governing all aspects of EMHS. According to the NPSSP, the inappropriate prescription and sale of medicines is most prevalent in the private sector due to profit driven motives and the sale of prescription medicines without prescription is widespread due to gaps in the regulatory framework and weaknesses in enforcement.

The current policy framework supporting the pharmaceutical sub-sector is comprised of the NMS Act (1993), the National Drugs Policy and Authority Act (1993), the Public Procurement and Disposal of Public Assets Act (2003), and National Medicines Policy 2015 (See Table 7.2). Several other policy actions have shaped the pharmacy sub-sector including the elevation of the pharmacy section to a division within the MoH, the conversion of the Central Medical Stores (CMS) into an autonomous entity, the establishment of the National Medical Stores (NMS) in 1993 and passing of the 116 Vote (2009/10), which ensures a budget line for medicines and supplies in the national budget.

7.1.2 Institutional Framework

The MoH's Pharmacy Division and NDA are the main policy and regulatory bodies in this sub-sector. In addition, other regulatory bodies - the Pharmacy Council, the Pharmaceutical Society of Uganda and the Allied Health Professionals Council - oversee specific aspects of the pharmaceutical sub-sector (see Table 7.3 and Figure 7.1).

Figure 7.1 Institutional Arrangements to Regulate the Pharmaceutical Sub-Sector

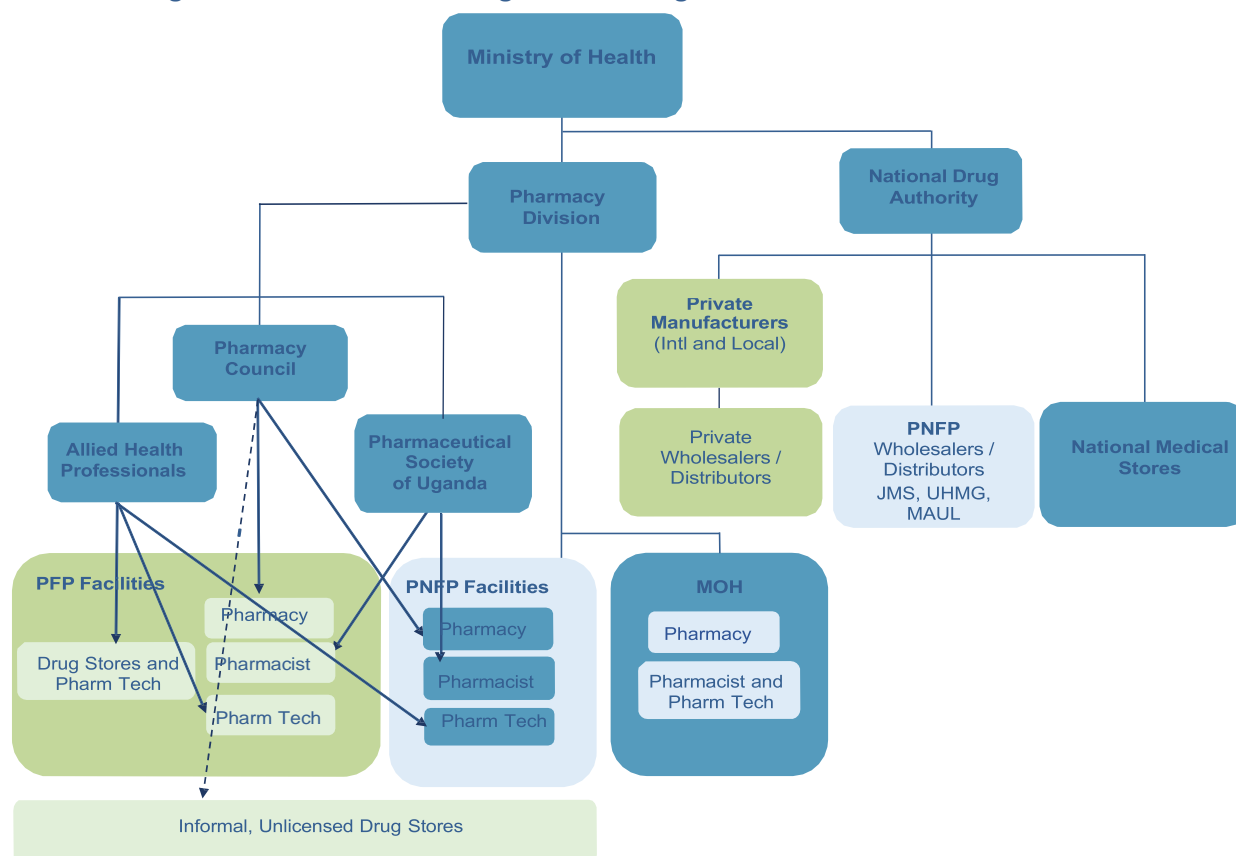


Table 7.3: Pharmaceutical-Sub Sector Regulatory Institutions

Institution	Legislation	Role
Pharmacy Council	Pharmacy and Drugs Act (1970)	<ul style="list-style-type: none"> Established the Pharmacy Council (formerly Board) to oversee profession Registers and licenses pharmacies
Pharmaceutical Society of Uganda	Pharmacy and Drugs Act (1970)	<ul style="list-style-type: none"> Established PSU Regulates pharmacy professionals
National Drug Authority	National Drug Policy and Authority Statute (1993) and National Drug Policy (2002)	<ul style="list-style-type: none"> Provides for medicine and health supplies distribution system for both the public and private sector Assigns roles and responsibilities to different institutions to facilitate distribution throughout Uganda Defines strategies to ensure supply, selling and distribution are regulated and to monitor manufacturing, wholesale and retail activities
Pharmacy Division, MoH	Health Sector Strategic Plan 2001/2009 (2008)	<ul style="list-style-type: none"> Elevated the Pharmacy Division to a department within MoH Sets policy direction for the sub-sector Mobilizes resources and human resource for the sector Develops plans for medicines procurement Develops guidelines and standards for the sub-sector Provides technical support supervision with other DHMT's
Allied Health Professionals Council	Allied Health Professionals Statute (Section 35) (1996)	<ul style="list-style-type: none"> Establishes AHP to represent private dispensers as a profession Registers and oversees operations of private drug shops Licenses private dispensers and pharmacy technicians

Pharmacy Division MoH. The Pharmacy Division in the MoH develops policies, coordinates pharmacy services and monitors their performance. The Pharmacy Division also mobilizes resources from government and donors, and establishes budgets for pharmacy services offered in mostly public health facilities. It has three staff (2 principal pharmacists and 1 Senior Pharmacist) that supervise 1,002 public pharmacies, 31 pharmacists, 112 Local Governments – DHOs - and 233 pharmacy technicians in the public sector. They also monitor the performance of the public sector’s supply chain and pharmacy services to inform the MoH and other stakeholders of sectoral challenges and propose recommendations.

The Pharmacy Division developed the comprehensive NPSSP III, and launched it in December 2015 in alignment with the NMP 2015. The NHP II and the HSDP 2015-2020 informed both the NMP and NPSSP. Many stakeholders interviewed are optimistic about its implementation and believe it is a major first step towards efficiently monitoring the sector. However, an operational plan is still in draft form. By the time of the PSA, the Pharmacy Division’s costing of the plan had yet to be finalized. Since the 2015/2016 fiscal year will be spent mostly disseminating the NPSSP III, an implementation plan needs to be put in place soon to ensure the Policy and Plan achieve their objectives.

National Drug Authority (NDA). The Pharmacy and Drugs Act of 1970 and 1993 Act of Parliament set up the NDA as an autonomous body under the MoH with the mandate to ensure the availability of high quality, essential, efficacious and cost-effective medicines to the Ugandan population. NDA monitors and controls the quality of pharmaceuticals in both the public and private sector supply chain, from importation and production through to storage and retail sales (See Box 7.1).

With a staff of about 100, a key responsibility of the NDA is ensuring the quality of EMHS supply in Uganda. The NDA is responsible for regulation of local production as well as registration of all pharmaceuticals used in the country. As part of its routine activities, NDA conducts site inspections of local drug manufacturers, quality testing on imported and counterfeit drugs, and post market surveillance.

Due to its limited human resource capacity and financing, NDA lacks sufficient capacity to carry out its mandate effectively (stakeholder interviews). It does not receive an annual budget and relies on fees paid by importers and local manufacturers charged for inspection, registration, quality control and information vetting activities. NDA management reported that the lack of resources hinders its ability to develop staff skills, invest in technology transfer, and purchase relevant equipment. Previously, the NDA received substantial development assistance. Currently, however, it has only limited sources of funding and does not receive any annual statutory allocation from the government (UNIDO, 2009). This arrangement presents a potential conflict of interest as the NDA is expected to regulate the entities upon which its financial survival depends.

NDA’s effectiveness is hampered further by the weak existing laws, which are not punitive enough to deter illegal practices and/or counterfeit products. In 2014, the GOU Cabinet moved to transform the NDA into a National Medicines and Food Authority. This transformation will expand the NDA’s mandate to include food monitoring to ensure that foods consumed by the public are also safe. The proposed Food and Drugs Authority Bill, which will have a dedicated government budget, will also expand the NDA’s jurisdiction to enable it better regulate foods and medicines. The NDA is optimistic this Bill will increase its revenue base as it will increase the number of players that the Authority will regulate.

Box 7.1 NDA Roles/Responsibilities

- Regulating import and export sales of EMHS
- Promoting and control local production of EMHS
- Ensuring quality of EMHS
- Regulating pharmacies
- Developing and updating the Essential Drug List
- Promoting rational use of EHMS
- Establishing professional guidelines
- Encouraging research and development of herbal medicines

Pharmacy Council. The Pharmacy and Regulatory Act (Chapter 280 Laws of Uganda) established the Pharmacy Council in 1970. When the Act was revised in 1983, it provided the NDA with the EMHS regulatory role and the NMS with the distribution role. The Pharmaceutical Society of Uganda (PSU) consolidated the role of regulating pharmaceutical professionals during this time and therefore the Pharmacy Board became largely redundant. The Pharmacy Council, housed in the MoH, oversees the registration and regulation of pharmacies. The Pharmacy Council does not license pharmacists but rather registers and disciplines them. It also maintains and distributes an updated list of gazetted and registered pharmacies, which currently stands at 735 registered pharmacies. The Pharmacy Council collects a registration fee that is part of a consolidated pharmaceutical sector fund within the MoH. A Pharmacy Bill has been proposed and is currently under review by MoH. One of its main roles will be to delineate and streamline the roles and responsibilities of the Pharmacy Council and the other regulatory actors in this space.

Pharmaceutical Society of Uganda. The PSU, the oldest regulatory society established in 1960, regulates pharmaceutical professionals in partnership with the National Council for Higher Education. It was formed in 1960 and received statutory recognition in 1971 through an Act of Parliament. All practicing pharmacists – irrespective of sector in which sector they work – are obligated to register with the PSU. The Society is responsible for enforcing professional pharmacy standards, monitoring and evaluating pharmacy training and pharmaceutical training. It is also involved in legislation, particularly reviewing existing Acts and frameworks, and development of standards that include a code of conduct for professionals. The Society provides quarterly supervision to pharmacies, universities, and research centers in the seven geographic regions of the country. It currently has 985 registered pharmacists with an annual membership growth rate of fifteen percent (15%).

Allied Health Professionals Council. The Allied Health Professionals Act Cap 268 established the Allied Health Professionals Council (AHPC) in 1996 to regulate, supervise and control the training and practice of Allied Health Professionals in Uganda. The AHPC licenses Pharmacy Technicians, Dispensers and pharmacy auxiliary staff that support pharmacy staff in stock management such as nurses, midwives, storekeepers, and store assistants. Pharmacy technicians staff most of the hospital pharmacies. Lower level facilities that do not have dispensers use nurses or nursing assistants to run the pharmaceutical services (ECSA-HC, 2010). AHPC regulates 23 health professional cadres as can be seen in Table 7.4 below.

Table 7.4. Allied Health Professionals Council Cadre Categories

Category	Cadre	Category	Cadre
Assistant (3)	1. Health Assistant	Technologist (3)	15. Dental Technologist
	2. Medical Laboratory Assistant		16. Medical Laboratory Technologist
	3. Theatre Assistant		17. Orthopedic Technologist
Officer (5)	4. Anesthetic Officer	Technician (1)	18. Medical Laboratory Technician
	5. Environmental Health Officer	Therapist (2)	19. Occupational Therapist 20. Physiotherapist
	6. Orthopedic Officer		
	7. Public Health Dental Officer		
8. Vector Control Officer			
Clinical Officer (6)	9. Anesthetic Clinical Officer	Miscellaneous (3)	21. Dispenser 22. Health Inspector 23. Medical Radiographer
	10. Clinical Officer		
	11. Ear Nose and Throat Clinical Officer		
	12. Medical Laboratory Scientific Officer		
	13. Ophthalmic Clinical Officer		
14. Psychiatric Clinical Officer			

Source: AHPC Files, 2016

Industry Associations. There are several non-profit organizations representing different private sector groups active in the supply chain and they lobby government on the behalf of their constituents. Key among them are: i) Uganda Pharmaceutical Manufacturers Association (UPMA) that advocates for government support to enhance competitiveness of local manufacturers; ii) the Uganda Pharmaceutical Promoters Association (UPPA) that brings together importers of medicines and health supplies in Uganda; tiii) he Uganda Small Scale Industry Association (USSIA) that represents interests of all registered small scale manufacturing firms in Uganda; and, iv) the Uganda National Chamber of Commerce and Industry (UNCCI) the umbrella organization for all private sector businesses in Uganda.

7.1.3 Quality Framework

Quality in the pharmaceutical sector has several components, ranging from assuring quality of drugs in the supply chain, to proper storage and distribution, to inspecting facilities and prescribing practices by qualified personnel. In Uganda, *these tasks are fragmented between the various regulatory bodies but also between the public and private sector.* NDA is responsible for assessing medicines for quality, safety and efficacy. The Pharmacy Council is responsible for inspecting both PNFP and PFP facilities, but not MoH pharmacies. Quality monitoring is NDA’s responsibility. Previously inspection was only for private sector retail pharmacies and drug shops. Currently, the NDA, working with MoH, has widened its scope to inspect and certify public sector facility pharmacies to enhance quality too in the public sector. This helps address the double standards on quality issues for public and private pharmacies. The Annual Pharmaceutical Sector Performance Report (APSPR 2012/2013) confirms these trends (See Table 7.5 below). According to this report, NDA is inspecting and certifying an increasing number of public sector health facilities for good pharmacy practice (GPP) as well as inspecting more private pharmacies and drug shops inspected and certified (APSPR, 2012-13).

Table 7.5: Number of Pharmacies and Drug Shops Inspected by Year

Year	Private Facilities		Public Facilities
	Pharmacies	Drug Shops	Pharmacies
2010/2011	747	11,785	0
2011/2012	709	6,925	0
2012/2013	976	6,140	605
2013/2014	901	5,984	1,002

Source: APSPR, 2012/2013

7.1.4 Private Sector Perspective on Policy and Regulation of Pharmaceutical Sub-Sector

Stakeholder interviews provided context for and an understanding of the policy framework in addition to its impact on the private providers working in the pharmaceutical sub-sector.

Out-of-date and contradictory policies. Several stakeholders across the board indicated there are many regulations that are out-of-date, particularly as they relate to introduction of new technologies and medicines (MOH-Health Systems 20/20, 2011). Moreover, there are laws that contradict current practice and policies within the sector e.g. for medical equipment and new medicines.

Regulatory framework is fragmented and confusing. Although by law the NDA has the primary responsibility of regulating and assuring quality in the pharmaceutical sector, the MoH Pharmacy Division also performs many of its responsibilities. As Figure 7.1 and Table 7.3 illustrate, there are many agencies performing similar and different roles – creating confusion for an outsider such as a PHP. For example, both the MoH Pharmacy Division and the NDA have the mandate to ensure access to affordable, quality EMHS.

However, the lines are blurred between which agency is specifically responsible for what, resulting in overlap and possible duplication of roles and this fragmentation leads to confusion and lack of accountability.

Multiple agencies are responsible for professional licensing. The PSU is responsible for licensing pharmacists but the Pharmacy Council only registers (e.g. keeps track of them) and disciplines them. The split of roles and responsibilities between the PSU and Pharmacy Council is a major obstacle to streamlining and making regulatory functions efficient in this sector. Typically, Pharmacy Councils in other SSA countries (WHO, 2011) perform this function⁴⁷. Another area of duplication and inefficiency is licensing of pharmacy technicians. The AHP licenses a pharmacy technician whether s/he works in a pharmacy or a drug store. From a private provider perspective (who has to renew his/her staff professional licenses on an annual basis), this myriad of institutions creates confusion, duplication of roles and costs.

Duplication and overlap also occurs in facility licensing and inspection. The NDA licenses pharmacies and so does the Pharmacy Council. The drug stores are handled differently. Private pharmacy and drug shops are also visited by multiple agencies. The AHPC inspects facilities for the health cadres they supervise but at the same time, NDA also inspects the same pharmacies and drug shops.

For the local manufacturers, multiple inspections abound. Since the NDA generates most of its income from fees paid by importers and local manufacturers, fees are charged at several steps, including inspection, registration, quality control and information dissemination. This poses a potential conflict of interest (MoH/SURE, 2011).

The overlapping regulatory roles create loopholes that can easily be exploited by both the public and private sectors working in the pharmaceutical sector. The fragmented regulatory framework has allowed informal and unlicensed drug shops to flourish with impunity. Therefore, the large number of different policy players has inherently created regulations that are difficult to enforce and left gaps exploitable by health centers, practitioners and suppliers alike.

Supportive policy framework but weak implementation. Although the policy framework facilitates a private sector role in many aspects of the pharmaceutical sub-sector, the challenge remains the actual implementation of these policy and strategies by the MoH and other line ministries (UNIDO, 2009). Many private sector stakeholders shared their frustration that the MoH has written many good policies but there is no action to implement them. Some have proposed that there is no political will or interest among senior MoH leadership to work with the private health sector in this sub-sector

NDA regulation and oversight of private pharmacies appears to be improving. The NDA ensures quality by licensing facilities combined with routine supportive supervisions and spot check inspections. Nearly all the private pharmacies visited by the PSA Team had up-to-date registration certificates from the AHPC. They reported that they received regular quarterly or semi-annual visits from the Regional NDA supervisors. By all accounts from the stakeholder interviews, there is better coordination at the regional level since the inspection is conducted regularly.

A number of studies have highlighted problems associated with drug outlets in Uganda. These include inadequate information given to patients, irrational drug sales or the inappropriate use of medicines, and illegal sale of prescription drugs (Birabwa et. al, 2014). By law, NDA must register **all** drug shops and pharmacies annually. Although most of the pharmacies visited for the PSA in urban areas were registered by the NDA, the drug shops that were more prevalent in the rural areas were often registered by the AHPC.

⁴⁷ WHO, 2011. Policy and Legal Framework, Effective Pharmaceutical Supply Chains

Quality of drug supply is a problem that adversely affects private pharmacies and drug stores. During the field interviews, private pharmacies mentioned they did not find any difficulty in procuring quality supplies or specific medicines due to the abundance of private suppliers who source products from reliable importers and research and development companies. However, they felt drug supply is insecure with a lot of counterfeit medicines and test kits in the market place. They felt government had an active role to play to ensure that genuine suppliers supply standard/quality or good drugs. The NDA acknowledges this challenge and admits that limited resources hamper its capacity to monitor all customs entry points. Despite these challenges, the quality of pharmaceutical products imported into the country has improved over the years. The NPSSP III (2015 – 2020) indicated that the proportion of imported products failing quality tests fell from 11% in 2010/11 to 4% in 2013/14. Private pharmacies also outdo their public sector counterparts when it comes to quality. Out of the 901 private pharmacies inspected in 2014, 98% passed inspection while of the 1,002 public pharmacies/dispensing outlets inspected in the same year, less than half (49%) passed inspection (NPSSP III, 2014). This illustrates the need to have one standard for quality in both sectors- public and private to avoid double standards.

Poor supervision and oversight of pharma HRH, a common practice found is a pharmacist and/or pharmacy technician registers a drug shop and disappears during the day. Only a handful of pharmacies and drug shops visited had a qualified pharmacist or pharmacy technician on site at the time of the visit. The absence of qualified pharmaceutical personnel leaves the day-to-day operations to lower-level cadres not trained in pharmaceutical skills, such as nurses, midwives, and nursing assistants. Often, the pharmacy or drug shop supervisor has a job elsewhere in a neighboring public health facility.

Limited interactions with the MoH. There is a general feeling from the private sector pharmacies and drug stores stakeholder interviews that the private pharma sector is operating in isolation from the public sector. Private providers in the pharma sub-sector are rarely invited to health sector planning and policy meetings at the district and national levels. One stakeholder described how he had to gate crash a MoH meeting to discuss the National Medicines and Food Bill (2014) even though the private sector will be one of the stakeholders most affected by this new bill if it is passed. Many of the pharma stakeholders noted that government needs to be more inclusive and to work with the professional associations to ensure their perspectives are represented. One stakeholder cited the current renovations of Mulago National Referral Hospital as a case in point. The PSU was neither consulted nor given a chance to review the plans and designs of the new unit, which includes a pharmacy.

Private providers complained of the limited support from government authorities and mentioned that the government only comes around doing spot checks or inspecting a case that has been reported. Because there is no formal channel of communication, the private pharmacists and pharmacy technicians often miss out or are not informed of a new health policy, regulation or operating procedure that directly affects them. Many of the private pharmacists and pharmacy technicians cited the limited opportunities and access to effective training and updated policy materials, which become impediments to running their operations.

Cumbersome reporting requirements. The private pharmacies and drug shops visited acknowledged and mostly complied with the annual requirements to renew staff and facility licenses. However, many did not report information on a regular basis to the MoH. They cited reasons such as; the HMIS 105 form being cumbersome and consuming a lot of time, lack of simple, easy-to-use reporting tools and templates in addition to not seeing any immediate benefits associated with reporting their data.

7.2. Public and Private Supply Chains

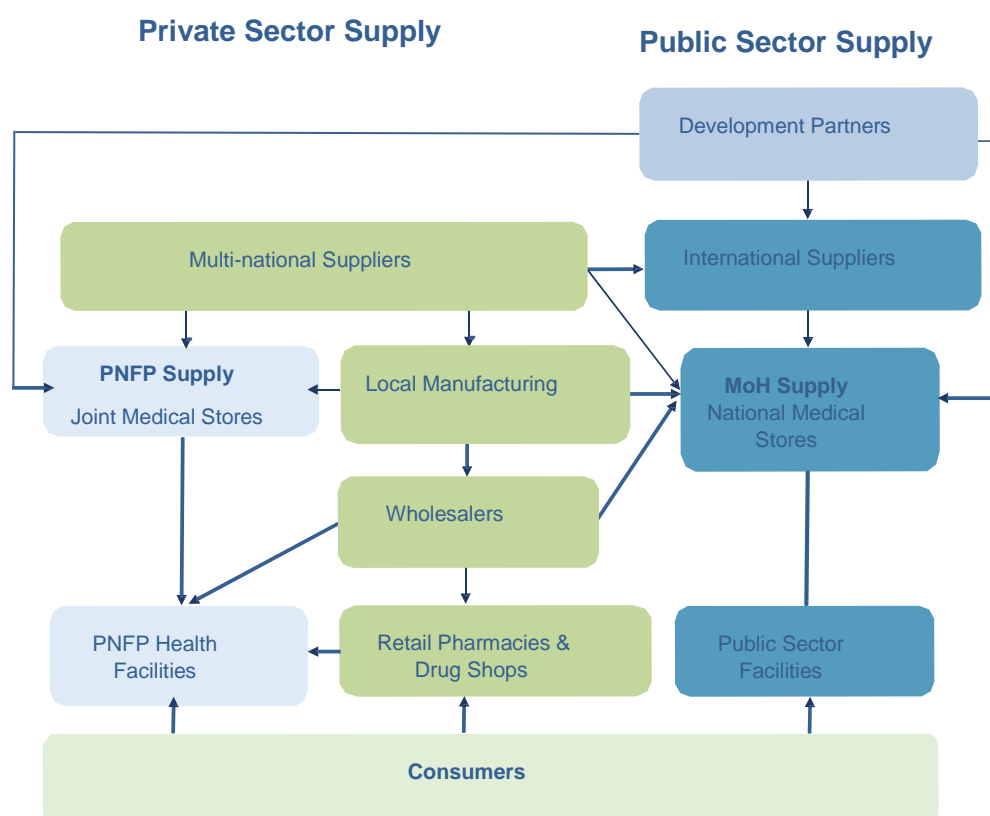
7.2.1 Overview

Over the last two decades, the demand for medicines and health supplies in Uganda has been increasing steadily. While it is to some extent a natural consequence of population growth, the rapid growth in the number of pharmacies and drug shops across the country indicates that there is a growing market and the population's ability to purchase EMHS has generally improved (UNIDO, 2010). Most of the growth in supply has occurred through the private sector. According to key informants, this growth has occurred in urban areas where nearly 80% of pharmacies are located (in Kampala, Jinja and Mbarara). This section discusses the public-private mix in the supply and distribution of EMHS and the private sector's growing role.

Three Parallel and Uncoordinated Systems. Uganda's pharmaceutical supply chain is composed of three, mostly parallel sub-systems. These systems have evolved over time resulting from the government's inability to deliver EMHS (MoH/SURE, 2011). The fragmented system started 20 years ago when DANIDA stepped in with emergency funds to supply EMHS through a parallel system to the National Medical Stores. This secondary system was later integrated by 2002 into the national public supply system. In the mid-2002s, the public system received a dramatic influx of donor funds to push critical drugs needed to respond to the HIV/AIDS epidemic and the donor driven supply programs created further fragmentation by establishing vertical supply chains for HIV/AIDS and TB drugs and supplies. In some cases, the national programs used the same product but sourced and financed by different donors. In other cases, some donors did not trust the MoH's capacity to handle their commodities and to scale up access to new treatment to meet donor targets (POA, 2011).

Figure 7.2 offers a simplified view of the Uganda EMHS sub-sector, which is too complicated to map all the players (MoH/SURE, 2011). In addition to the public supply chain, there are two similar supply chains on the private sector side – one owned and operated by the PNFP sector and the second one is purely private, commercial supply chain. As illustrated, there is considerable overlap between the public and private sectors at different levels within the supply chain, depending on the nature of the medicine being distributed (UNIDO, 2009).

Figure 7.2: Simplified Diagram of Uganda EMHS Sub-Sector



Public-Private Mix in Infrastructure. The lack of accurate and consistent data on important activities related to the Ugandan supply chain is a direct outcome from the fragmented and inefficient regulatory framework. The information in Table 7.6 was not readily available from any one of the regulatory agency and therefore compiled from various and independent sources. The NPSSP III (2015 – 2020) indicates there are 5,984 authorized drug shops, 901 private pharmacies, 69 importers, and nine local manufacturers. Yet the Pharmacy Council indicated there are 735 registered pharmacies although acknowledged that this number is most likely underreported. The true number of unregistered and unlicensed outlets, especially drug shops and drug sellers, is unknown.

Table 7.6: Public-Private Mix of EMHS Organizations by ownership

Type of Entity	PFP	PNFP	Private (Total)	Public	Overall Total
Importers	68	1	69	1	70
Manufacturers	8	0	8	1*	9
Wholesalers/Distributors	N/A	N/A		-	372
Pharmacies (Retail)	N/A	N/A	901	1,002	1,903
Drug Stores	N/A	N/A	5,984	-	5,984

Source: NPSSP III, APSPR 2013/14, UNIDO 2010 report

N/A – Not available

* Quality Chemicals is a joint venture-ship between GOU and private investors

Table 7.6 shows that the private sector plays a significant role in the pharmaceutical sector in Uganda and is active in every stage of the supply chain starting from importation, to local production, to distribution and retail of EMHS. It comprises the largest number of manufacturers, importers, and drug stores. It is only matched by the public sector when it comes to the total number of retail pharmacies.

HRH in the Pharmaceutical Sub-Sector. The Annual Pharmaceutical Sector Performance Review states that there has been a sizeable increase in the overall number of practicing pharmaceutical personnel. The pharmacist to population ratio increased from 1.1 pharmacists per 100,000 persons in 2010/11 to 1.6 pharmacists per 100,000 persons in 2013/14 - a 10% increase in less than three years. Although similar than other SSA countries, this ratio is still low compared to other low and middle-income countries (APSPR, 2014) and considerably below the WHO recommendation of 1:2,000). Since pharmacist retention is low in the public sector, the government has put forward recommendations to increase the number of pharmacy technicians in the sector while also trying to increase the overall number of pharmacists. In addition to the low number of pharmacists, almost 90% of these pharmacists are concentrated in the central region (Cooper and Dayna, 2013), creating HRH shortages in other regions in Uganda.

Table 7.7 shows that the majority of HRH for the pharma sector work in the private sector. The private sector employed over 93% of pharmacists and 69% of pharmacy technicians. A 2011 analysis of the pharma sub-sector revealed that most pharmacists and pharmacy technicians prefer to work in the private sector and therefore attracting the most qualified and competent pharmacists (MoH, 2012)⁴⁸. Moreover, vacancy rates are still high in the public sector pharmacy positions, leaving other health cadres to carry most of the pharmaceutical management functions without proper training. The stakeholder interviews also reveal there is dual practice among public sector pharmacists. For instance, interviewees reported that it is a common practice for one to own and operate a private pharmacy that is located close to a public sector facility, which they also work in.

Table 7.7: Pharmacists and Pharmacy Technician Filled Positions by Public/Private Sector

Pharmacy Personnel	Private	Public	Total
Pharmacists	916	69	985
Pharmacy Technician / Dispenser	318	233	551

Source: APSPR 2013/14.

The private sector plays an important role in educating and training HRH in the pharmaceutical sector. In Uganda, only three private universities train pharmacists at the undergraduate level. The School of Pharmacy Technicians also trains Pharmacy Technician, while the PSU plays an active role in the continuing education of pharmacists. In 2014, the three universities passed a total of 76 pharmacists and 54 pharmacy technicians.

Total Size of Pharmaceutical Market. Although there is no official data available, in 2009, the pharmaceutical market in Uganda was estimated to be worth around US\$276 million (Ohairwe et al, 2009). Stakeholders interviewed stated public-private mix of total medicines is 40% delivered through public channels and 60% through private means (including PFP and PNFP sectors). Uganda Investment Authority estimates that 90% of all medicines are imported, accounting for 5.4% of Uganda's total imports (MoH, 2012)⁴⁸. Stakeholders estimate that between 80% and 90% of all pharmaceutical imports originate from India and, increasingly, China. Also, some medicines are imported from neighboring Kenya and Tanzania. Although many of these imports are generics, many brand-name medicines are readily available in the private sector.

⁴⁸ Ministry of Health, Health Systems 20/20, and Makerere University School of Public Health. April 2012. *Uganda Health System Assessment 2011*. Kampala, Uganda and Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

7.2.2 Public Supply Chain

Although the NMS is the main actor in the public supply chain, there are other entities outside of the public supply chain that also help the MoH fulfill its mission, underscoring the duplication and overlap of the public and private supply chains.

National Medical Stores. In 1993, the NMS Act established the NMS as a public semi-autonomous body to distribute supplies to public health facilities. The NMS procures, stores, and distributes EMHS. It does not maintain any warehouses of its own but rather uses district warehouses, managed by the local governments, which function as distribution hubs for its supplies. Through a bi-monthly ordering and delivery schedule, NMS uses a pull system to provide medicines to HC IV and hospital level facilities. The public health sector is a popular source of medicines because they are supposed to be provided free of charge in all public health facilities. A WHO study found that 46% of Ugandans receive their medicines from the public sector (MoH/SURE, 2010).

The problems plaguing the public supply chain are well documented. Key medicines are only available at half (47.5%) of public health care facilities, 75% of prescribed medicines are actually dispensed, and over 70% of government health units have monthly stock outs (UNIDO, 2009 and MoH/SURE, 2011). Stock outs often mean that patients attending public sector facilities have no choice but to purchase prescribed medicines from private pharmacies and drug shops where costs of medicines are three to five times more expensive (UNIDO, 2009). However, the MoH's Annual Sector Performance Report 2014/15 reports an improvement over the previous three years.

International Procurement Agents. NMS and JMS are the main procurement agencies for public and PNFP health facilities. To ensure competitive prices, NMS and JMS pool their procurements. They regularly compare their prices to the median international buying prices and strive to keep prices 100% below international price (APSPR, 2013 - 2014).

Donors have become big players in EMHS and support several not-for-profit agencies to procure and distribute key drugs and address many of the supply issues found in the public sector. Examples include Medical Access Uganda Limited (MAUL) for USG funded agencies, CHAI for pediatric formulations procured by UNITAID, and the Global Drug Facility for TB and leprosy commodities.

Procurement in the public sector is still a vertical process with different funding agencies using different procurement agents and procedures (MoH/SURE, 2011). The government has put forth recommendations to centralize quantification and procurement functions in a Quantification Unit to streamline the activities of the different agencies.

Public Sector Pharmacies. The public sector has 1,002 pharmacies/dispensing outlets nationwide. Although all pharmacies, including those at public sector facilities are supposed to have a full-time pharmacist on duty, this is not possible given the overall shortage in qualified, trained pharmacists in the market place. Moreover, the public sector is having difficulty recruiting and training pharmacists. As a result, public sector pharmacies increasingly rely on pharmacy technicians as well as other facility staff, such as nurses and midwives, to perform the duties of pharmacists. In 2013/14, the MoH started to inspect its own pharmacies just like their counterparts in the private sector. With the assistance of USAID's Securing Ugandans' Rights to Essential Medicines (SURE) Project, the NDA, in partnership with the MoH Pharmacy Division, established a certification program whereby the MoH inspects public and/or PNFP pharmacies for GPP. Certification guarantees a certain minimum standard of medicine management have been met.

7.2.3 Private Not-for-Profit Supply Chain

The Joint Medical Store (JMS) owns and operates the largest supply chain outside of the public sector. However, other not-for-profit organizations in the marketplace have emerged in response to donor funds to accelerate drug supply in the public sector.

Joint Medical Stores. In 1979, the Catholic Church and the Church of Uganda formed JMS as an independent organization to procure and distribute medicines and supplies to the PNFP sector. In recent years, JMS has extended its clientele to private pharmacies and drug shops due to their proliferation and the understanding that many of these private providers, particularly in rural and remote areas are the only healthcare providers available for the poor. JMS also supplies public health facilities when they experience stock-outs.

JMS has a reputation for quality products and many private providers source from it when uncertain of supplier or product quality. JMS still relies on commercial vendors to transport its medicines so it regularly monitors them to ensure they comply with good distribution practices. JMS is the only private sector player with national reach and continues to invest in its capacity to reach the ‘last mile’ distribution and to improve warehousing. Its distribution centers in major towns across the country help JMS achieve economies of scale and therefore maintain similar prices countrywide.

JMS has plans to expand its distribution capacity, particularly in the area of warehousing. JMS plans to set up regional warehouses across the country. Because JMS is a not-for-profit entity, it is not eligible for commercial loans. The only possible source of capital would be from the government, which it has lobbied. However, despite JMS’ large volume and its close association with both the public and PNFP facilities, JMS has not yet received government support.

Donor supported PNFP Distributors. The pharma sub-sector also has large-scale donor supported HIV/AIDS and malaria programs, which run as parallel medicine-specific supply chains. Most prominent are MAUL, Baylor Uganda, and Uganda Health Marketing Group (UHMG). All three are funded by USAID. The donor supported PNFP distributor system includes four funding sources (PEPFAR, UNITAID/CHAI, GOU, and GFATM), five procurement agents (MAUL, SCMS, UNITAID, CHAI, NMS, and Crown Agents), and multiple storage and distribution entities. Together, there are eight (8) separate systems and 25 sub-systems. It is understandable that a major donor partner would want to work through a familiar system to avoid loss or mismanagement, but there are serious drawbacks of multiple supply systems.

PNFP Pharmacies. Most (78%) of the PNFP providers are FBOs managed and supported by their respective medical bureaus (MoH/SURE, 2011). As noted earlier, JMS supplies all pharmacies in FBO health facilities. FBO pharmacies are usually staffed by a pharmacy technician or a nurse that doubles as a dispenser. The PSA Team confirmed this practice. Out of the 14 FBO pharmacies visited for the PSA, 7 had a pharmacy technician or dispenser on site at the time of the visit and they are supervised by a pharmacist supervised 3 of them. In total, a full-time pharmacist supervises slightly less than half of the FBO pharmacies. These numbers are comparable to those of the PHP pharmacies.

7.2.4 Private-for-Profit Supply Chain

Uganda has a vibrant and growing PFP supply chain with private actors involved in every aspect of the medicine supply chain.

International Procurement Agents. The NDA developed procurement guidelines in accordance with the NDA Act CAP 206. This Act stipulates mandatory registration of all imported drugs unless given special clearance by NDA. In addition, all importers must have a valid import permit, which might be annual or provisional and issued by NDA. As of 2010, Uganda had twenty-three private procurement agents. Since the government does not set a minimum or maximum range for margins, the procurement agents can set their own prices.

The Coalition for Health Promotion and Social Development (HEPS) in Uganda publishes a list of retail prices for the 40 drugs on the MoH essential medicines list semi-annually. A year-to-year comparison of these prices indicates minimal variations probably due to the large number of suppliers that keeps prices suppressed.

Local Manufacturers and Suppliers. According to the Ugandan Investment Authority, local manufacturing has experienced steady growth since the 1990s. As of June 2009, local production was estimated to have an annual value of US \$ 27.6 million, representing less than one percent (0.18%) of Uganda's GDP (UNIDO, 2010)⁴⁹. Although local manufacturing is largely dominated by SMEs, which account for over 90% of the establishments, there are 5 large and 6 small-scale pharmaceutical manufacturing companies. If functioning at full capacity, these local manufacturers could meet the demand for most of the essential drugs for the Ugandan population. However, in practice, this is not happening (META Medicines Report, 2010) and Uganda still imports 90% of EMHS needs.



As of 2009, the NDA had licensed 19 companies to produce EMHS in Uganda of which only 11 are involved in commercial production of pharmaceuticals (UNIDO, 2010). Four of the manufacturers operate on large scale: Abacus Parenteral Drugs Ltd. (infusions and injectables), Medipharm Industries Ltd. (Oral Rehydration Salts), Kampala Pharmaceutical Industries Ltd. (KPL) and Quality Chemicals Ltd. (mainly generic essential medicines). The remaining 9 pharmaceutical manufacturers are mostly medium and small size. Of the licensed manufacturers, one is producing injectables, one is producing ORS, one is producing ARVs, and two are producing ACTS. Only one of the 19 local manufacturers, Quality Chemicals Industries Ltd, is WHO pre-qualified and is working on product pre-qualifications for ARVs and ACTs (see Box 7.2)

There are some incentives to encourage further growth in local production of EMHS. Unlike Kenya and Tanzania, Uganda does not have preferential schemes for local companies in public tenders. The Uganda Pharmaceutical Manufacturing Association successfully lobbied government to allow locally manufactured pharmaceuticals a 15% preferential price margin in public procurements. However, as of 2015, the scheme had not been implemented. Since 2014, the PPDA Amendment act has been before Parliament for approval. The new law will apply preference schemes to goods, works and services, where open domestic or open international bidding methods are used.

Some locally manufactured pharmaceuticals are exported to nearby countries with the hope that further integration of the EAC market will provide considerable market opportunity (UNIDO, 2009). Many local manufacturers cite the 15% preferential margin will allow them to become more competitive in the regional market place.

Wholesalers and Distributors. Uganda has 16 large distributors and an equivalent number of warehousing entities. Many of them are part of the donor supported private ARV supply chain such as MAUL Uganda and the UHMG. They procure, store and distribute EMHS for all sectors (MoH/SURE, 2011).

⁴⁹ UNIDO, 2010. Pharmaceutical Profile: Uganda.

Most of the pharmaceutical wholesalers are also importers and this trend is on the rise. In the field, the PSA Team found that many importers doubled as wholesalers, distributors, and even retailers. In the areas of malaria, tuberculosis, and HIV/AIDS, there is no private market as donor funds provide the necessary medicines to the public sector and donor supported distributors supply these same medicines to the private sector. Although this is noteworthy, it should be balanced with the government's efforts to support local manufactures to produce medicines locally (stakeholder interviews).

Box 7.2 Quality Chemicals Ltd: Example of Public-private-partnership in Local Manufacturing

GOU recognizes that depending on foreign pharmaceutical imports - especially for essential medicines like ARTs - poses a number of challenges. Reliance on imports drives the cost of drugs up, can create shortages in the market and uncertainty on the quality of drugs. The World Trade Organization's (WTO) Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement barred pharmaceutical manufacturing firms from supplying medications still under patent to low and middle-income countries such as Uganda. However, TRIPS allowed these countries to set up pharmaceutical facilities and manufacture patented medicines.

Recognizing the potential as well as the need for key drugs, Quality Chemicals Ltd. (QCL) of Uganda, approached the GOU with its proposal to manufacture locally antiretroviral and antimalarial drugs. The GOU facilitated the PPP by introducing QCL to Cipla as well as offering the newly formed joint venture a two-year government guaranteed loan.

The partners – QCL, Cipla and the GOU – established Quality Chemicals Industries Limited Uganda (QCIL) in 2007 under a provision of the Ugandan PPP Act that allows international firms to establish a local business by partnering with a local Ugandan firm. Cipla and QCL own equal shares. The goal of the partnership is to provide Uganda a reliable source for ARV's and ACT's.

The PPP has yielded positive benefits for both the partners and the health sector. The initial government loan has since been paid off and QCIL currently has total assets worth US\$120 million. QCIL has created meaningful employment for between 250 – 300 staff work full-time and over 1,000 part-time employees. Eighty percent (80%) of the full-time staff have technical training in manufacturing and GPP.

The company passed GPP certification and is awaiting WHO pre-qualification certification. In 2014, QCIL received NDA manufacturing approval for Duomune, a Tenofovir-based drug which is the MOH recommended first line treatment of HIV/AIDS. To date, the government allocates UGX 100 billion (US \$30 million) every financial year to the National Medical Stores (NMS) to procure anti-retroviral drugs from Cipla QCI. (The Observer, 2016). Cipla QCI also foresees significant growth prospects in other areas and recently started production of Hepatitis B medicines based on its long-term projections of the disease in Uganda. (CIPLA QCI website, 2016)

Retail Pharmacies and Drug Stores. Private pharmaceutical retailers include licensed stand-alone pharmacies and hospital pharmacies in addition to many unlicensed pharmacies in private providers' clinics, unregistered drug shops, and other health care entrepreneurs. According to the NDA website, there are 1,158 licensed pharmacies and drug stores countrywide. Private pharmacies are authorized to sell prescription-only medicines as well as over the counter (OTC) medicines. Drug stores focus on OTC but in some cases, they are allowed to sell prescription-only medicines.

Private pharmacies and drug stores can play an important role in distributing essential medicines to urban but also rural and remote populations. It is estimated the private sector accounts for approximately 50% of the health service delivery and as much as 70% of all drug outlets (MoH/SURE, 2011). For example, the Uganda government classified Artemisinin-based Combination Therapy medicines as OTC in 2008. The Policy Options Analysis for Uganda's Pharmaceutical Supply System (POA) study (MoH/SURE, 2011) found that 71% of drug outlets selling ACTs were private sector facilities. Another 2013 study found that drug shops were the most convenient source of short-acting contraceptive methods for family planning clients of low socioeconomic status (Akol, 2013).

However, there are challenges in relying on private pharmacies and drug stores as a mechanism for increasing access. In private retail outlets, the choice of medicines dispensed is largely dependent upon the person operating the pharmacy, usually a trader and not a professional pharmacist. The in-charges are expected to determine the difficult balance between professionalism and commercial benefits. A 2009 study found that the latter is always more attractive, leading to the obvious choice of low-cost high-margin products. The NPSSP III (2015 – 2020) detailed significant deficiencies in the development and enforcement of regulations governing handling and dispensing of prescription only medicines in private retail pharmacies.

Quality in drug stores is a well-documented problem. For example, many of the drug shops visited by the PSA Team sold several non-OTC drugs, such as the antibiotics Metronidazole and Doxycycline, to clients even without a prescription. A 2014 study conducted within 57 parishes in Mukono district found that a third (29.4%) of drug shops reported antibiotics as the first-line treatment for children with diarrhea, yet the standard guideline is to give ORS and zinc tablets (Mbonye A.K. et al, 2015)⁵⁰. Quality could be improved under proper supervision of a pharmacist, but according to current regulations, each pharmacist can only supervise a maximum of two pharmacies or drug stores. This means at the current number of 985 registered pharmacists, there should be no more than 1,970 drug stores yet Table 7.6 shows there are at least 7,000.

7.2.5 Development Partners

Several development partners support the pharmaceutical sector:

- **DANIDA**, in the early 2000s supported capacity building at the NMS, the MoH Pharmacy Division and facility level. In addition, DANIDA provided technical assistance to help reform the pharmaceutical sub-sector as well as fund EMHS. The support was phased out with the launch of the SURE Projects.
- **United States Government (USG)** supports multiple initiatives through different programs. USAID has supported multiple bi-lateral programs – DELIVER, Supply Chain Management Systems (SCMS) and SURE Projects – which all focused on building the public sector capacity as well as procurement of a wide range of EMHS. PEPFAR also donates ARTs and other needed drugs and supplies to address HIV/AIDS but under a vertical supply chain.
- **Multi-lateral Organizations**, such as United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), Global Alliance for Vaccines and Immunizations (GAVI) and the GFATM and the World Bank, offer technical assistance and procure EMHS.
- **Not-for-profit organizations**, like Clinton Health Access Initiative (CHAI) and Bill and Melinda Gates Foundations (BMGF), offer similar assistance as the USG and multi-lateral organization programs. Both CHAI and Africa Affordable Medicines (AAfM) established drug sellers/store networks.

7.2.6 Private Sector Perspective on Fragmented Market

Private sector stakeholders also shared the challenges of working in a pharma sub-sector in which there are multiple supply chains.

Multiple supply systems create problems. As seen in other countries in the region, multiple systems creates problems. For the public sector, the challenges are well known: i) human and other resources are wasted; ii) coordination between parallel systems serving the public sector is weak; iii) there is duplicate inventory and storage systems; iv) management information is incomplete and fragmented; and,

⁵⁰ Mbonye AK, Buregyeya E, Rutebemberwa E, et al. Prescription for antibiotics at drug shops and strategies to improve quality of care and patient safety: a cross-sectional survey in the private sector in Uganda. *BMJ Open*. 2016;6:e010632. Doi:10.1136/bmjopen-2015-101632.

v) there are multiple reporting requirements (POA, 2011). However parallel systems have created problems for the private sector as well. With multiple suppliers and distributors, there is no incentive for private firms to invest in infrastructure to achieve the economies of scale needed to reach all geographic areas in Uganda.

Poor coordination among supply chains. Procurement is not well coordinated among private sector entities, procurement agencies and the public sector. Weak quantification, forecasting and demand management in the public supply chain results in overlap of efforts and parallel supply chains. Private providers working in the pharmaceutical sub-sector expressed a willingness to work more closely with the public sector to address the various challenges confronting NMS. Examples included better coordination between the sector of available stock, public-private collaboration to address public facility stock-outs, and sharing best practices and expertise to reduce wastage. Nevertheless, many reported that the MoH is reluctant to partner with the private sector, particularly with the PFP sector. Moreover, there are regulations that prevent cooperation (e.g. the public sector is prohibited from purchasing supplies from private suppliers).

Crowding out in key segments. According to stakeholder interviews, the private sector is no longer active in heavily donor-supported areas such as malaria, tuberculosis, and HIV/AIDS.

7.3. Funding of EMHS

Since 2002, financing for EMHS has increased significantly – particularly with the advent of global health initiatives such as PEPFAR and Global Funds. Whereas the additional funds have provided opportunities, they have also posed various challenges, particularly as parallel procurement and distribution mechanism exist. Financing of EMHS comprises a significant proportion of health expenditure. According to the NHA 2011/12, medical goods are the fourth largest health expenditure in Uganda (9.4%), after out-patient curatives (44%), in-patient curative (26.9%) and preventive services (NHA, 2011/12) and this is a low estimate since both in-patient and out-patient curative costs have medicine costs in the NHA computations. In a different study, drug costs are the public sector's second largest expense after staffing (MoH/SURE, 2011).

Box 7.3 Uganda Health Expenditures of EMHS

- Uganda health system spent 303,350 UGX million on medical goods in 2011/12
- Consumers financed the largest percentage of this amount: 74% OOP compared to 26% free through the MoH facilities
- Approximately 10% of all OOP expenditures were spent on medicines
- WHO recommends a maximum of only 15% from OOP to avoid catastrophic spending by households.

Source: NHA 2011/12

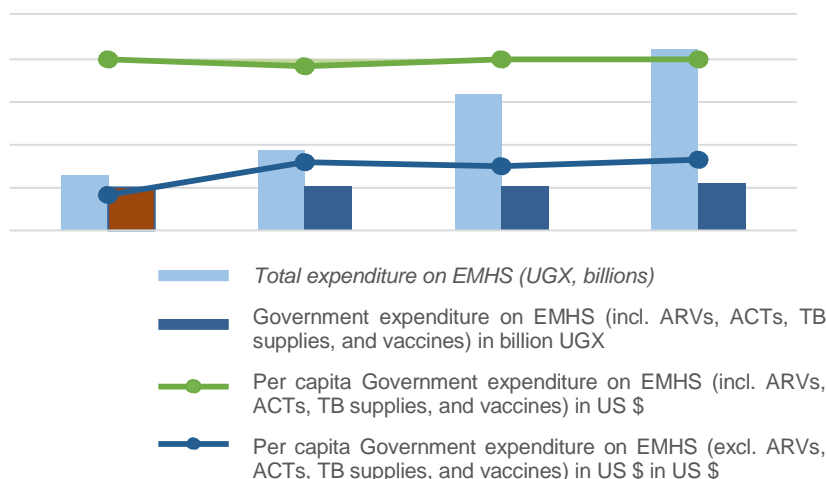
Although there is need for increased government allocation to the public sector to cover EMHS and other costs, there is also space to improve efficiency of public spending. A World Bank study revealed that there is still considerable wastage in the public supply chain due to i) direct drug leakage (theft);, ii) poor procurement and supply management leading to waste; and, iii) poor prescription practices (World Bank, 2010). The same report highlighted another factor contributing to public supply chain inefficiency – increased volume of third-party procurements (e.g. donor-supported commodities). Poor coordination and cost of handling, storing and distribution of the third-party procurements has created additional costs for NMS as well as duplication and overlap of functions. Another study revealed that (US \$ 2.4 million of drugs expired between 2005 and 2007, of which 82% were donor products, of which 82% were donor products (MoH and SURE, 2011).

7.3.1 Total Expenditures on Drugs

According to the APSPR 2013/2014, total expenditure on EMHS has increased steadily over the past few years. From 2010 to 2014, overall expenditure on medicines increased by an average of 27% per year from UGX 258 billion in 2010 to UGX 846 billion in 2014 (see Figure 7.4).

However, excluding donor funds, government health expenditures have remained mostly stagnant over the same period. From 2010 to 2014, government spending on EMHS increased from UGX 202 billion in 2010 to UGX 219 billion in 2014. Government per capita spending on EMHS also remained the same at an average of US \$2.40 per capita. When ARVs, ACT's, TB supplies, and vaccines are excluded, government per capita expenditure nearly doubled from US \$0.50 to US \$0.98. These funding levels are inadequate by all measures. As noted in the APSPR 2013/14, the average per capita on EMHS including ARV's, ACT's, TB supplies, and vaccines since 2010 (US \$2.40) constitutes less than half of the government's HSSIP target of 21% of total health expenditures spent on EMHS.

Figure 7.4 Trends in Government Expenditure on EMHS



Source: APSPR, 2013/14

7.3.2 Sources of Funding for Drugs

Public-Private Mix of Funding for EMHS. According to the NHA 2012/13, there are two primary sources of funding for medicines and supplies: public and private. Almost three-quarters (73.9%) of all drug expenditures are financed by private sources, which are mostly individual households paying OOP including development partners. Government, including development partner contributions to drug and other related supplies, funds 26.1%.

Table 7.8 Distribution of OOP Expenses by Service FY 2012/13 (US \$ millions)

Category	Amount	% of Total
Medicines	3,164.9	59.0
Other expenses/Transport	1,304.2	24.0
Hospital/Clinic Fees	606.9	12.0
Traditional doctor's fees/Medicine	165.8	3.0
Consultation Fees	123.4	2.0

Private OOP Spending on Drugs. When examining how individuals spend their money in health, Table 7.8 shows that the clear majority – 59% – is spent on medicines. The amount individuals spent on drugs in 2012/13 is considerable - US \$ 367.4 million. One of the reasons why individuals spend so much of their health dollars on drugs is the constant stock-outs in public health facilities, requiring individuals to go to a PNFP or PFP pharmacy to supply their drugs (APSPR, 2013/14).

Public Spending on Drugs. A positive change was the creation of Vote 116 by Parliament in 2009, that ensured a dedicated government budget line to NMS for the procurement of EMHS) for public sector facilities. It considerably improved medicines availability in the public sector, in terms of quantity, range of items and quality. Under this Vote, the government allocated US\$66 million towards annual medicines in 2014/15.

According to the MoH APSPR 2013-2014, overall funding by government and development partners has increased since 2010/11. Drug expenditures have more than tripled from US \$99m in 2010/11 to US \$325m in FY 2013/14. Development partner funding has driven the growth during this period. Development Partner funds increased from US \$76m in 2010/11 to US \$250m in 2013/14 while government spending increased from US \$23m in 2010/11 to US \$75m during the same period (See Figure 7.6). Public expenditures on medicines as a percent of THE have increased from 6% in 2010/11 to 8% in 2013/14 (See Figure 7.5).

Despite the increase in public funding, the EMHS budget still covers less than one-third of the needs and two-thirds of total funding is dependent on development partners who fund mostly HIV commodities, malaria and TB supplies. Figure 7.7 (illustrates how public funds are allocated across commodities. The largest share of drug expenditures is allocated to ARVs and OI medicines (51%), followed by laboratory supplies and consumables - 17% (MoH, 2014).

Figure 7.5 Public Expenditures on Drugs as % of THE



Figure 7.6 Total GOU and Donor Expenditure on EMHS

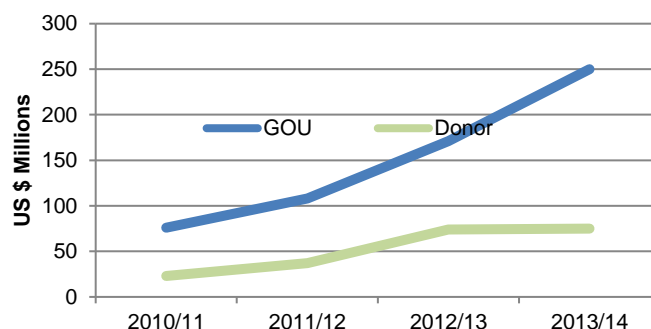
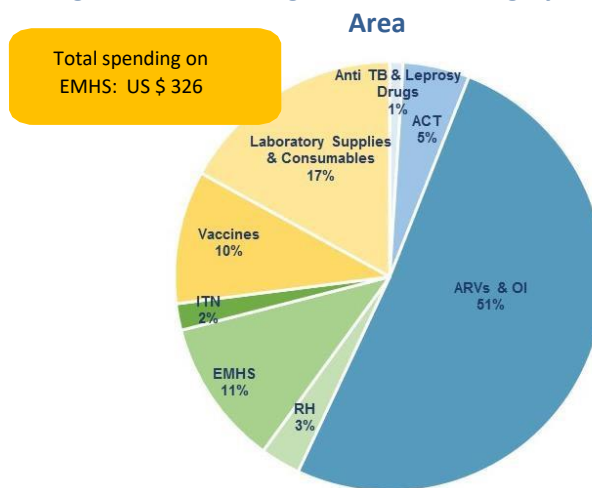


Figure 7.7 Percentage of Total Funding by Commodity Area



Source: APSPR 2013/14

It is interesting to note that many of the laboratory supplies are in relation to HIV/AIDS and TB. Only 11% of total commodity funding was spent on EMHS and 10% on vaccines.

Table 7.9 Source of EMHS funds by Funder

Source	% of Total
GOU	33.4
USAID	18.2
CDC	14.8
CHAI	10.4
GAVI	9.5
GFATM	4.0
DANIDA	2.4
AIDS Relief	2.4
UNICEF	1.5
UNFPA	1.5
Stop TB	0.3
MSI	0.1
Other	1.5
Total	100.0

Source: POA Survey, 2010

Donors play an important role in the financing of medicines; more than 70% of public expenditure on medicines is donor-funded. Among the Development Partners, the USG is the largest funder (33%), contributing the same proportion as the GOU. USG partners include USAID (18.2%) and CDC (14.8%) that mainly fund PEPFAR and PMI programs. The rest of the development partners fund ten percent (10%) or less of total drug costs (POA, 2010) (See Table 7.9).

7.3.3 Private Sector Perspective on Financing of Medicines

How drugs are financed also has an impact on private sector market potential in the pharmaceutical sub-sector. The current funding scenario is the least equitable, and disproportionately affects the poor Ugandans' ability to access needed drugs.

Insufficient public funding. Government spending on EMHS (not including ARVs, ACTs and TB medicines) is roughly estimated at about US \$ 1 per capita per year which is only about half of what the WHO estimates is needed for EMHS (APSPR, 2014).

Overly dependent on donor funding. Development partners have stepped in to fill the gap. Of the medicines required, the government budget only covers about thirty percent (30%). Uganda depends highly on the global community—particularly Global Fund, GAVI, and PEPFAR. With high donor dependency comes unpredictability of release of funds, which makes it difficult to plan and predict stock status and requirements.

Donor funds have crowded out the private sector. Because of the significant amount of donor funding to the public sector, the private market segment has declined to approximately thirty percent (30%) (MoH/SURE, 2011). In the areas of malaria, tuberculosis and HIV/AIDS, there is virtually no private market. As a stakeholder reflected, donor supply has dampened any local production of these essential products.

Patients struggle to pay for needed medicines. Ugandans, particularly the poorest, are left with few options on how to pay for drugs. With constant stock-outs in public facilities and without national health insurance to reimburse for drug expenditures, most Ugandans rely on private sources to purchase their medicines. The WHO 2004 study found that overall medicines were unaffordable to a large portion of the population.

7.4. Availability and Prices of Key Commodities

7.4.1 Availability

Availability of medicines continues to be a problem in Uganda. The WHO report on medicine prices revealed the primary reasons why consumers did not obtain a prescribed drug with the most commonly cited reasons were not available in a public facility and they did not have enough money to purchase it in a private (PNFP or PFP) pharmacy (WHO, 2004).

The PSA team conducted spot surveys of medicine availability and prices in both PNFP facility pharmacies and PFP retail outlets. The findings are similar to the 2004 WHO report. Generally, availability is enhanced in the PNFP sector compared to public, and better in PHP compared to PNFP sector.

7.4.2 Prices of Medicines

Mark-ups and prices vary from public, to PNFP and PFP providers. Figure 7.9 illustrates the cost components in a price sold in the private sector based on international averages. Import price (FOB), retail mark-up and importer mark-up are the three largest cost drivers.

- **Public drug prices.** Public health facilities do not charge user fees or the cost of medicines except for the private wings in referral hospitals.
- **Wholesale (purchase) price.** The public sector is paying more for drugs than it should (WHO, 2004). NMS is able to procure medicines and supplies at better prices when compared to the International Drug Price Indicator Guide (IDPIG). Inflexible PPDA regulations limit opportunities for NMS to achieve good procurement outcomes. Uganda could follow the lead of some other countries, such as Tanzania, by enacting a special regulation to supplement the PPDA rules that deal with the special needs of medicines procurement (POA).
- **Distribution cost.** Public facilities include a markup to cover the cost of transport and handling of medicines to the public health facilities.
- **Retail mark-up.** Despite the MOH policy to not charge for medicines, some districts continue to report high numbers of clients who claim to pay health workers informally so they can receive the medicines they need (EMHS Final Report, MoH).
- **Not-for-profit drug prices.** JMS is the principal supplier for medicines found in PNFP and NGOs health facilities.
- **Wholesale (purchase) price.** JMS offers the most competitive prices at the wholesale level. JMS appears to be more efficient than NMS and is able to purchase medicines for twenty-five percent (25%) lower than NMS prices (see Figure 7.8) (SURE Project, 2014). JMS does not face the same PPDA restrictions as NMS so it usually ends up with lower purchase prices and shorter lead times (Medicine Price Components, 2014).
- **Distribution cost.** JMS charges ten percent (10%) to fifteen percent (15%) margin to cover its storage and distribution costs (stakeholder interview, 2016).

- **Retail mark-up.** Unlike public health facilities, PNFP pharmacies are allowed to charge for the medicines they dispense. It appears that PNFP medicine prices are similar to those in the PFP sector. In some cases, NGO prices were higher than those found in PFP pharmacies. In such cases, the NGO facility is apparently marking-up the drug at a higher than average rate.
- **PFP drug prices.** Currently there is no policy or regulation establishing limits on mark-ups. Therefore prices in the private sector are set by market conditions.
- **Wholesale (purchase) price.** Private wholesalers who import for themselves impose a mark-up of 20% to 40% depending on product characteristics. NMS and JMS prices are more competitive than private wholesalers' prices. Both NMS and JMS prices are approximately 30% less when compared to private wholesale prices (See Figure 7.8).
- **Distribution cost.** These typically add a mark-up of 5 - 10% on products sold to their customers (USAID/Uganda PHS Program, 2014). This is considered the most highly competitive stage of the medicines supply chain especially since the mark ups have been declining over the past 10 years.
- **Retail mark-up.** A recent study shows that retail mark-ups range from fifty percent (50%) to six hundred percent (600%) (PHS, 2014). Medicines and commodities used in donor-funded projects such as contraceptives had lower retail mark-ups at level of care. The PHPs do not use a systematic method to determine the mark-up or set the price.

When comparing prices between all three sectors, PFP retail pharmacies have the highest prices to consumer when compared to other similar "private" pharmacies located in public and PNFP facilities. The average mark-up is 261% when matched to public hospital private wing (256%) and PNFP hospital private wing (264%) (see Figure 7.9).

Table 7.10 summarizes the Team's findings related to price variances by the different supply chains. As one can observe, there is no policy or regulation in place to standardize mark-ups or rationalize pricing. It is imperative to address this policy gap since drug purchases is the number one OOP expenditure and one of the key reasons for impoverishment in Uganda.

Table 7.10: Price Variances between Sectors

Public Prices	PNFP/NGO Prices	PHP Prices
<ul style="list-style-type: none"> • Purchase Price: NMS pays more than it should. Inflexible PPDA regulations limits NMS from achieving good procurement outcomes • Distribution: MOH pays 7% on ACT/ARV and 18% on EMHS % for the cost of transport and handling of medicines to public facilities • Retail Mark-ups: Reports that MOH clients informally pay health workers to get medicines 	<ul style="list-style-type: none"> • Purchase Price: JMS offers the most competitive purchase prices among the three sectors; estimated to be 25% lower than NMS • Distribution: JMS charges 10% to 15% margins to cover storage and distribution costs • Retail Mark-ups: PNFP are similar if not a bit lower than PFP prices. In some cases, NGO prices were high than those found in PFP pharmacies. 	<ul style="list-style-type: none"> • Purchase Price: Private wholesalers impose 20% to 40% mark-up depending on the product characteristics. NMS and JMS prices are approximately 30% less compared to private wholesale prices. • Distribution: They add a mark-up of 5 - 10% on products sold to retailers. Considered most competitive stage of supply chain. • Retail Mark-ups: Retail mark-ups range from 50% to 600%. Donor drugs and commodities (e.g. FP methods) have lower retail mark-ups at point of sale.

The PSA team also conducted a spot survey of medicine prices in both PNFP facility pharmacies and PFP retail outlets. The survey confirmed the SURE project's analysis of prices.

Table 7.11 Comparison of Median Medicine Prices in both PFP and PNFP Facility Pharmacies

Medicine		Private Sector	PNFP Sector
MATERNITY			
1	Fansidar	1,000.00	Free
2	Ferrous Sulphate	50.00	75(33% free)
3	Folic acid	125.00	100(50% free)
4	Misoprostol	2,250.00	2,000.00
5	Oxytocin	1,075.30	1,250.00
FAMILY PLANNING			
1	Injectables/Depo-Provera	1,500.00	Free
2	Condoms	500.00	Free
3	IUDs	22,500.00	12,500.00
4	Oral contraceptives	1,250.00	Free (1 response)
5	Pilplan (pills)	1,000.00	Free
CHILD HEALTH			
1	Amoxyl	3,000.00	2,500.00
2	ORS	500.00	275.00
3	Paracetamol	2,000.00	1,500.00
4	Vitamin A	1,000.00	Free
5	Zinc sulphate	300.00	250.00
HIV/AIDS			
1	Acyclovir	300.00	NA
2	Co-trimoxazole	100.00 (27% free)	Free
3	Efevarenc	Free	Free
4	Fluconazole	750.00 (27% free)	NA
5	Niverapine	Free	Free
6	TDF/3TC/EFV	NA	Free

Factors Considered in Pricing Medicines. The USAID/Uganda Private Health Support Program 2014 Costing and Pricing studies identified four factors used by private facilities when setting prices for medicines and supplies. They include:

- **Health facility overhead costs.** Lower health facilities and hospitals set the highest mark-ups for all products due to higher operating costs (e.g. overhead, staff, laboratory, etc.).
- **Purchase price.** Retailers tend to keep margins low on innovator drugs purchased from a private wholesaler because the already high cost would make the product unaffordable. In contrast, retailers tend to set a high mark-up on generics because they could to obtain these products at a cheaper price from the wholesaler
- **Turnover of products and frequency of use.** The study shows that medicines to treat common diseases, such as malaria and common infections, tend to move faster and have a higher turnover rate. Many private facilities stock these commonly used drugs. Large volume and high turnover in stock help keep the price of fast moving drugs low and stable.
- **Government and/or donor subsidies.** Programs that have government or donor subsidies, such as TB, HIV/AIDS and PMTCT, had stable mark-ups. NMS levies a ten percent (10%) mark-up to cover administrative and handling costs. The MOH pays this fee and the medicines are delivered free of charge to participating private health facilities. Other commodities distributed in private facilities participating in government programs, like FP methods, health supplies for MCH, also had the same ten percent mark- up. In exchange for donated drugs, these medicines are delivered free of charge

in private facilities. Social marketing programs, which allow private retailers to charge for the medicine, institute a maximum retail price.

7.4.3 Private Sector Perspective on Price and Other Market Conditions

The combination of weak policy and regulatory framework, limited government support for a private sector role, and financing of medicines in the Ugandan pharmaceutical sub-sector create difficult market conditions for the private pharmaceutical sector. Stakeholder interviews revealed several obstacles that prevent private sector growth, but also limits their capacity to partner with MoH to address many of the persistent challenges found in this sub-sector.

Lack of access to capital. Key informant interviews in the private pharmaceutical sector highlighted high interest rates and lack of financing as the biggest challenges hindering their growth and operations. For example, JMS has plans to create regional warehouses yet they are unable to access the capital needed not only because of the high cost but also because they are a non-profit and therefore considered “not credit worthy” by commercial lenders. Distributors interviewed want to expand their transport system to create greater economies of scale and therefore reducing transport costs. Nevertheless the high costs of capital coupled with the lack of incentives has demotivated local distributors from borrowing money to carry out expansion and to modernize their operations.

Difficult market conditions for local manufacturers. Many stakeholders interviewed feel that the growth in the sub-sector is not as fast as expected. The interviews confirmed that the challenges highlighted in UNIDO 2009 report persist today:

- Difficulty in accessing government incentive due to fragmented policy position between several government agencies – MOH, MOFPED and Tourism, Trade and Industry
- Limited access to local or regional markets supported by donor funds which require WHO certification and/or product prequalification
- Unfair competition from low-cost imported medicines from India (accounts for 60% of all imports in Uganda) and China where local manufacturing receives direct support from their respective governments to build capacity and promote exports abroad
- Competition from donor supplied commodities, such as condoms, pills and others, that crowds out the market for potential manufacturers
- Limited access to new technologies resulting in use of outdated technology
- Difficulties in importation of all raw materials
- High operational costs attributed to high costs of land, electricity and other utilities
- Limited availability of qualified HRH in quality management and compliance with international standards
- Difficulty in achieving WHO pre-qualification standards without government support

Government incentives insufficient to grow private pharmaceutical manufacturing sector. The National Drug Policy provides incentives for local pharmaceutical manufacturers of essential medicines, such as tax incentives, tender preference, reduced import tariffs on inputs, reduced rates for electricity and water consumption. It also mentions support in improving local pharmaceutical technical capacity by encouraging and assisting in staff training. However, it has been difficult for local manufacturers to access these benefit (UNIDO, 2010) due to cumbersome processes and paperwork. Local manufacturers noted they were trying their best given the circumstances but felt they were still largely disadvantaged when other governments, such as India, provide subsidies to Indian manufacturers to compete in the Uganda marketplace while the Ugandan government does not offer the same to Ugandan companies.

Market entry too low. The ease of opening up a retail pharmacy or drug shop makes the sector, especially at retail level, a low cost, high volume and low margin business. A 2013 study by Cooper and Dayna noted that in Uganda, anyone, irrespective of their qualifications, could open up and own a pharmacy. Margins are highest at the retail level with markups ranging anywhere from 50% - 600%. This arbitrary price setting at the retail level might be one of the reasons many still find medicines to be unaffordable. Nearly all the private pharmacies we visited faced problems of limited warehousing capacity. Except for the public and PNFP facilities supplied by the NMS and JMS respectively, nearly all other providers have to travel to wholesale distributors or retailers to pick up their supplies.

Out-of-date Policies. Uganda has no policy or legal framework that explicitly supports task shifting. Most of the current instances occur informally and without any documentation. The WHO provided guidelines and recommendations to guide policy makers and health workers on the implementation of task shifting. However, a 2014 case study found that policy makers were fearful once a policy on task shifting was formulated, its retrieval would be difficult in the event task shifting did not work as expected. Others are afraid of ‘task piling’ or ‘task dumping’, by higher cadres, of unattractive roles or responsibilities. The pharmacists’ profession has the least number of positions filled amongst all health sectors in the country. At national level, the proportion of approved positions in the public sector filled by trained health professionals was 28% for pharmacists, compared to doctors (52%), Midwives (67%), nurses (58%), clinical officers (66%), and health assistants (61%).

The huge number of unsupervised pharmacies and low pharmacist to population ratio suggest a need for task shifting. Yet the Pharmacy and Drugs Act 1971 explicitly mentions “No person shall open... to the public for the sale of drugs [a] ‘pharmacy’... or ‘drug store’... unless a pharmacist is on the premises and is supervising the activities carried on.”

In Uganda, only the national and regional referral hospitals have pharmacists. Pharmacy technicians or dispensers are the ones found in most other hospital pharmacies. Due to the shortage of pharmacists, the pharmaceuticals sector relies heavily on pharmaceutical technicians/dispensers who are also employed in many of the hospitals. In other sectors, such as nursing, nurses at the registered and enrolled level have taken on increasingly more roles of a clinical nature—beyond the scope of work of a traditional nurse—due to human resource shortages. They are now allowed to insert intravenous lines, prescribe medications, and treat patients – tasks typically performed by doctors and clinical officers (USAID Case Study). Changes to the laws governing the scope of practice of non-pharmacists around operating a pharmacy and prescribing medicines are yet to happen.

Take Home Messages on Supply Chains and the Private Sector

- Parallel supply chains have created fragmented and overlapping systems that suffer from poor quality in drug supply and delivery, have created inefficiencies and driven up costs. Until the government and international donors decide on how to approach consolidation of the three supply chains, this situation will persist.
- The private supply chain will continue to do “work arounds” to survive in this market, perpetuating inefficient distribution and high costs. With MoH facilities continuing to experience drug stock-outs leaving the private sector as the major supplier of medicines, the poor will be disproportionately affected by the high prices in the private sector.
- The private sector is the dominant player in all aspects of the supply chain. Yet they face tough market conditions, such as lack of quality HRH, particularly pharmacists; weak regulations and oversight of the sector; competition from both licensed but also “quacks”; high costs of inputs (e.g. purchase price, transport costs); and donor crowding out in select drugs and markets.
- The stakeholder interviews revealed little or minimum interaction between the public and private sectors on supply chain issues. Moreover, the public sector has not fully exploited private sector infrastructure and expertise to address the endemic problems in the public supply chain.

7.5. Recommendations to Harness Private Sector in EMHS

The Assessment team, in consultation with stakeholders, identified the following recommendations that would help the government harness private sector capacity to make drugs more affordable and accessible.

1. **Streamline and modernize the regulatory system governing EMHS supply.** As noted in this section, there is confusion related to the roles and responsibilities between the NDA and MOH Pharmacy Division and the Pharmacy Council.

It would be opportune for the MOH and NDA to review how other countries, particularly middle-income countries like China and Brazil, have modernized their pharmaceutical sector to look for strategies to streamline and consolidate not only the regulatory framework and institutional arrangements but also the EMHS markets. Areas to pursue include: 1) consolidating and streamlining the government institutions responsible for pharmaceutical sector oversight, 2) clarifying the newly consolidated roles and responsibilities and linkages to the private health sector, 3) modernizing oversight systems and tools to make them more management oriented for the regulatory agencies and “user-friendly” for private sector businesses in the pharmaceutical sector, and 4) collecting better data on *all* supply chain activities by *all* – public, PNFP and PFP alike – entities working in the pharmaceutical sector and consolidating this data into one place so that both government and non-state actors can access the information as needed.

Finally, engaging the PNFPs, PHPs and businesses working in the pharmaceutical sector to design and modernize the regulatory system as they will be the stakeholders most affected by these changes.

2. Assist JMS to establish regional warehouse network. JMS has invested considerable resources to develop an investment plan to build regional warehouses. The objective is to create a network of warehouse in six regions to reduce their cost of transport and make stocking timelier. JMS plans to construct warehouse that will accommodate not only their own distribution and warehouse needs but also those of the NMS and private operators with plans to lease space. They project that a regional warehouse network will consolidate and create efficiencies in these two components of the supply chain. However, they do not have sufficient capital to construct this network of warehouses and cannot secure a loan through commercial lenders because of their non-profit status. The GOU can assist JMS to raise needed capital by; 1) guaranteeing a commercial loan, 2) lending the funds to JMS with favorable terms, or 3) entering into a PPP arrangement in which JMS builds and operates on behalf of both JMS and NMS.
3. Help grow local capacity to manufacture key medicines and health products. The 2010 UNIDO report made several recommendations that merit repeating in the PSA as government actions. They include; 1) offering tax exemption on imports of raw materials and machinery, 2) reducing costs of inputs such as water, power, etc, 3) promoting Ugandan manufacturing in other markets, particularly East African markets where Ugandan companies are competitive, and 4) assisting local manufacturers to qualify for GPP certification and WHO prequalification status.
4. Identify other PPPs opportunities with local manufacturers. The GOU and Quality Chemicals PPP demonstrated the benefit of partnering with a local manufacturer in order to become 100% self-reliant in ART. The GOU can: 1) explore other PPPs opportunities to manufacture essential/generic medicines that can be sold both in the Ugandan and regional markets, 2) facilitate more international partnership like QCIL to establish presence in other country markets and 3) offer favorable conditions similar to those in the GOU/Quality Chemicals PPP to incentivize more PPPs in pharmaceutical manufacturing.
5. Establish a policy to buy locally manufactured products first. Similar to other countries, the GOU can put into effect regulations that guarantee MOH / PNFP contracts purchase drugs made by local manufacturers.

6. Make drugs and essential health products more affordable. Clearly, drug costs to consumers is the number one health expenditure. Any effort to rationalize drug prices and to make drugs more affordable will go a long way to reduce the likelihood of many Ugandan families becoming poor as a result of a health expense. The POA outlined recommendations that would help make drugs more affordable, such as 1) creating guidelines to establish minimum/maximum ranges for mark-ups on key drugs only, 2) establishing affordable MoH prices to recoup costs and 3) establishing a drug benefit plan for the poor to remove economic barriers to essential medicines (See Box 4.x in Health Financing Section).
7. **Make drugs and essential health products more accessible.** Several East African countries, including Uganda, are experimenting with different strategies to legalize, consolidate and strengthen quality of drug sellers and drug shops. In Tanzania, the MoH and Social Welfare spent 10 years to approve regulations that legally establish ADDOs as licensed facilities and drug shop owners as a professional health cadre.

With USAID support, they trained over 8,000 ADDOs owners to improve GPP and business skills. The ADDOs, However, are not formally networked like the Pharmnet example in Kenya (see Box 7.3). In Kenya, the MoH had difficulties closing unlicensed drug shops run by unqualified quack providers, which undermined consumer confidence in the licensed pharmacy technicians, so the Kenya Pharmacy Association created a formal network to brand licensed providers and assure quality of their products. In Uganda, the Clinton Foundation is attempting to network drug shops in rural areas.

The team recommends the MoH and NDA examine the different country examples that incorporate the lessons learned and best practices from each in order to design a drug shop network. Such a network can serve as the administrative entity with which the MoH can contract for the proposed Drug Benefit Plan. The network would be responsible for assuring compliance, quality products, and GPP.

They would also process and pay claims, assure drug shop owners do not charge for the drugs, and monitor for fraud. Depending on the arrangement, the MoH could donate the drugs to reduce their cost of the program and/or require the network manager procure the drugs on the open market. In addition, the MoH could run various health prevention programs recommended in Section 6, such as TB, FP methods and childhood illness through the network.

Box 7.3 Networking Peri-Urban and Rural Drug Shops: *Pharmnet Experience*

Pharmacies are the first point of contact for the majority of Kenyans seeking healthcare. Yet, of the 12,000 pharmacies in Kenya, only 4,000 are licensed with the Pharmacy and Poisons Board. Consumers cannot be confident in the quality, authenticity and value of the medicines they purchase. With little disposable income (KSh100-300, the equivalent of \$0.60-2.00 per day), this low-income group is forced to pay directly OOP for healthcare and is hit by the 'poverty penalty' - paying multiple times for healthcare as the initial service from informal operators did not properly treat the illness.

The Kenya Pharmaceutical Association (KPA) - a professional association representing licensed pharmacy technologists - wanted to address the issue of illegal practitioners. KPA has over 7,000 paying members and as an established and well-managed professional association, they offer many member services including: i) advocacy and policy with the Kenyan MoH on behalf of the members, ii) market and clinical information, and iii) CPD training and certification.

KPA created a network to increase consumer confidence in pharm techs – as they are commonly referred to in Kenya – and the quality of the products sold in pharm techs' drug stores. KPA formed a commercial entity (NTP) to become the network manager and branded it "Pharmnet". In order to join Pharmnet, each a network member has to qualify to become an eligible affiliate. The members undergo rigorous training in GPP; counselling and customer services; reporting to the MoH; and, business and financial management skills. NTP also offers required refresher training annually.

With more branding set to take place and the rollout of Pharmnet posters in Kenya's brightly decorated matatus (buses), complemented with radio adverts blaring to passengers, KPA is scaling up the intervention, aiming to have 1,000 Pharmnet outlets reaching up to nine million people by the end of 2017.

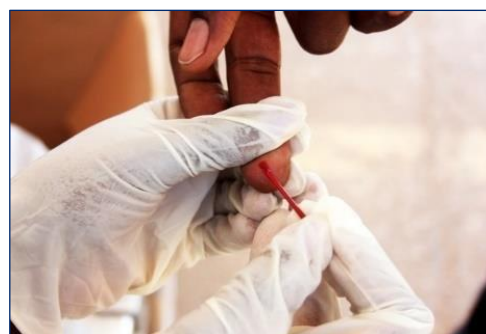
In exchange, the Pharmnet member receives access to affordably priced quality-assured drugs, improved community pharmacy practice, supportive supervision visits, and branding and promotion of the network. NTP pools procurement on select medicines (mostly essential medicines for priority health issues such as FP, diarrhoea, cough, malaria, TB) and sets price caps on these drugs. In 18 months, over 500 members nationwide have joined Pharmnet. Within three years, Pharmnet has become financially sustainable mostly from profits earned on pooled procurements but also through membership fees. Pharmnet plans to expand its network to include all 5,000 members over the course of the next three years.

Source: <http://www.psp4h.com/wp-content/uploads/2015/05/PSP4H-Case-Study-No.-7-Pharmnet-A-Sustainable-Community->



8. MEDICAL LABORATORY SERVICES

Effective laboratory services are an essential component of a functional health care system because labs not only generate information that enable timely and accurate diagnosis of disease but also play a key role in disease surveillance, provide essential data for health systems planning, disease prevention and control. Lack of reliable laboratory services results in delayed and inaccurate diagnosis of disease, leading to avoidable morbidity and mortality, drug wastage, high expenditure for government/organizations and individuals as well as loss of confidence in the health care system.



Although medical laboratory systems and public health laboratory networks are a vital component of Uganda's health system, this sub-sector has been one of the least developed and neglected in Uganda although Uganda is not unique in this aspect as pathology and medical laboratories in SSA have long been neglected (Elbireer, 2012). Never the less, exploring opportunities to build and maintain a strong medical laboratory infrastructure can potentially strengthen Uganda's whole health system.

However, it will take ensuring diagnostic capacity at all levels of both private and public laboratories to produce accurate and reliable laboratory results (Elbireer, 2012). This section provides an overview of the relationship between the public and private sectors in delivering laboratory services, weaknesses in the sub-sector in the health system, and opportunities to create greater efficiencies in lab services by harnessing private sector capacity.

8.1. Policy Environment Supporting Private Laboratory Services

Policies and regulations governing this sub-sector have been in place since 2009. There are several policies germane to the lab sub-sector. Below is a summary of the key documents that provide the policy foundation for all laboratories in Uganda with an emphasis on how they support private sector development in health laboratories.

Uganda National Health Laboratory Services Policy 2009 (NHLSP). As late as 2009, the laboratory sub-sector was operating without a policy framework and institutional arrangements to assure quality of laboratory services. In recognition of laboratory critical and essential role in the delivery of quality health care, the GOU passed the NHLSP in 2009. The policy puts in place a national framework for laboratory services in Uganda. It provides the rationale for a national framework, stating that poor health laboratory services subject patients to inappropriate treatments, chronic ill health and high OOP expenditures on health care, loss of incomes and ultimately loss of confidence in health services. Moreover, poor laboratory services are costly in terms of high wastage of scarce public resources on ineffective treatments, and loss of economic productivity of the population due to chronic illness and loss of life.

The policy acknowledges the existence of private sector laboratory services – both PNF and PHP – including the overall description of the range of laboratories operating in Uganda. In addition, the NHLSP clearly lays out areas of how the public and private sectors can work together to ensure quality lab services. Key areas for partnership include: i) sharing information, testing the capacity and resources, ii) contracting of specific lab services to increase efficiency and iii) creating mechanisms to encourage private providers to extend services to underserved areas.

The NHLSP is the only one in the health sector that clearly states that the entire policy applies to both the public and private sectors in the same way (NHLSP, Section 5, page 15).

It states that it is the equal responsibility of both the public and private sectors to work together to achieve the policy goals and objectives and that “all partners are called upon to bring this vision to a reality” (NHLSP, Section 6, page 15). In fact, the policy design created for the first time a spirit of collaboration and encourages all stakeholders to work together to ensure its implementation.

Uganda National Health Laboratory Services Strategic Plan (2010-2015). The MoH formed a National Health Lab Technical and Advisory Committee to draft the National Health Laboratory Strategic Plan 2010-2015 (NHLSSP). The purpose of the NHLSSP is to guide GOU and health development partners' investments in laboratory services. It aims to strengthen coordination, implementation and management of the laboratory services and ensures that they are transparent and responsive to the country's health needs. Although most of the NHLSSP focuses on how to strengthen the public health laboratory system, the NHLSSP recognizes the need to better collaborate and coordinate with non-state providers of health laboratory services to improve access and equity in lab services. Activities to strengthen public-private coordination include: establishing a position at the AHPC for a private sector representative, widely disseminating the laboratory code of ethics and standards to private providers, strengthening the Laboratory Professional Association as an entity representing professionals, and streamlining AHPC registration, licensing and inspection systems for lab professionals and laboratories.

The National Strategic Plans (HSSP I and II, and HSDP) recognize the contribution of the laboratory systems and their impact on the quality of health services and health outcomes. One of the strategies highlighted in those plans is the strengthening of the laboratory systems in order for them to support the implementation of the UNMHCP adequately, and the development of the NHLSSP, Laboratory Standards and Guidelines as well as their implementation.

Regional Policies in the Area of Medical Laboratories. International development partners such as the WHO and CDC have played important roles in strengthening laboratory services in SSA. With the emergence of the HIV/AIDS epidemic, millions of dollars have been invested to strengthen labs for testing. The 5th Regional HIV/AIDS Network for Public Health Laboratories agreed to broaden its scope to strengthen lab capacity. WHO-AFRO, in collaboration with CDC, CHAI, and the American Society for Clinical Pathology launched a stepwise laboratory accreditation process (5 Star), supported by the Strengthening Laboratory Management Towards Accreditation (SLMTA) capacity building project (Elbireer, 2012).

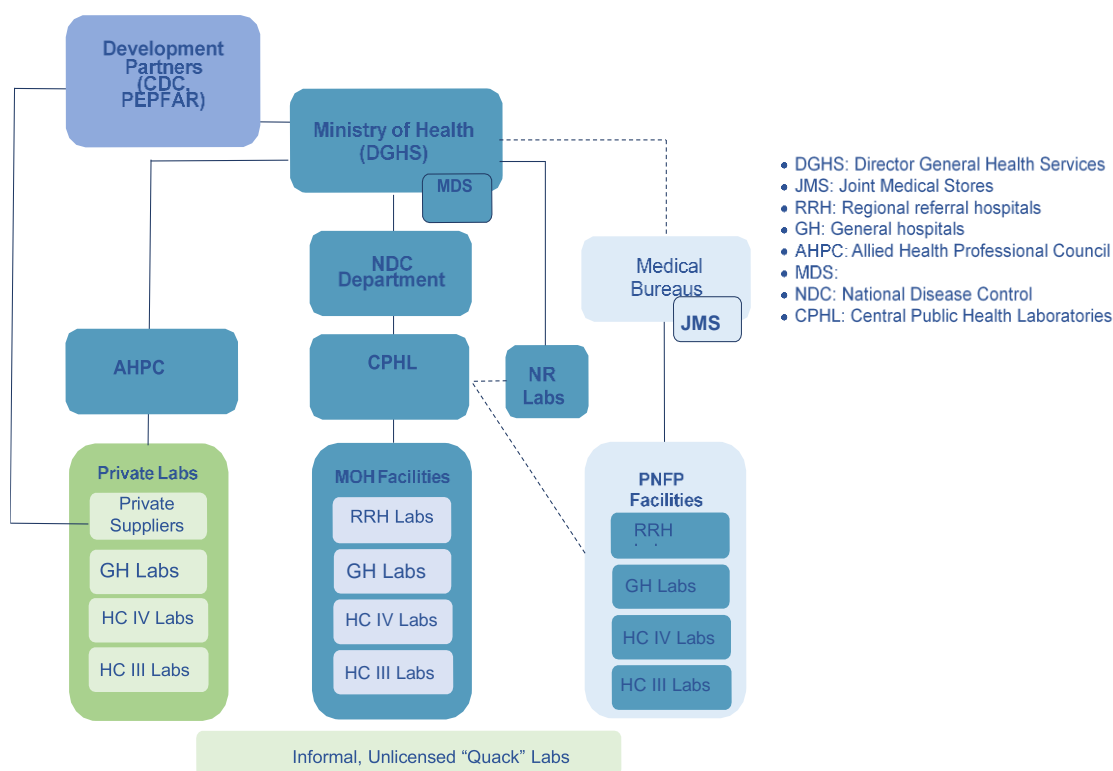
Table 8.1: Private Sector References in Uganda’s Economic Development Policies

Policy	References to the Private Sector
Ugandan National Health Laboratory Services (NHLSP) Policy, 2009	<ul style="list-style-type: none"> • Puts into place organizational and management structure for coordinating lab services, mobilizes financial and logistical resources needed for nationwide lab services, establishes a quality management system and monitoring and an evaluation system for lab services • Allows the MOH to contract private sector for lab services • Establishes a level playing field between public and private lab services by stating that “implementation will be in the same line within government, NGO and private sector
Uganda National Health Laboratory Services Strategic Plan 2010-2015 (NHLSSP)	<ul style="list-style-type: none"> • Overarching planning framework for the country’s investment to strengthen the lab sub-sector • Plan outlines 13 strategic areas including PPPs in lab services • Activities to focus public-private cooperation include strengthening APHC capacity, dissemination of standards and code of ethics, and streamlining lab certification, licensing and inspection.
HSSP I and II	<ul style="list-style-type: none"> • Recognizes link between access to health laboratory services and quality of health services but not many activities (nor budget) to strengthen lab sub-sector.
Regional Policy Initiatives	<ul style="list-style-type: none"> • HIV/AIDS projects on strengthening lab capacity agreed to move beyond a single disease focus to strengthening the entire laboratory system • WHO-AFRO launched the Five Star Accreditation System

8.2. Organization of the Health Laboratory Sub-Sector

Based on the NHLSSP 2010-2015, Figure 8.1 illustrates the government perspective of health laboratory sub-sector and the key actors within. Similar to the Medicine and Health Supply Chain, there are three parallel delivery mechanisms of lab services – government, PNFP and PHP. These delivery systems operate in different spheres with limited interaction and coordination. Donor funds from PEPFAR for HIV/AIDS and GFATM have greatly shaped the laboratory sub-sector. The rapid influx of funds from these donors has created a vertical laboratory system within the public one, which has only further fragmented the laboratory sub-sector (Elbireer, 2012). The only integration and coordination occurs between the MoH and the labs located within the FBOs. The MoH interacts closely with PNFP laboratories through supportive supervision, donated supplies, training and proficiency testing (NHLSP, 2010).

Figure 8.1 Uganda Health Laboratory Services Sub-Sector



Public-Private Mix of Laboratory Services

8.2.1 Public-private Mix of Laboratory Infrastructure

Table 8.2 shows the public-private mix in the Uganda medical laboratory sub-sector. As discussed in prior sections, the PSA team faced many challenges in securing reliable and up-to-date information on the current number of licensed facilities. Up until recently, the MoH did not collect data on labs, but in 2013, the MoH – with support from AHPC – conducted its first-ever assessment

of public and PNP labs and is now collecting regular data on this sub-sector. The data is scattered in different places for both the public and PNP sectors. Moreover, the data to classify labs is different from the health facility nomenclature used by the MoH (see Box 8.1) and lumps both PNP and PHP into one category.

Table 8.2 and Figure 8.2 show the number and percentage distribution of laboratories at HC IVs and hospitals by ownership. There are over one thousand laboratories in Uganda, but data is difficult to get for those at HC III and below. The MoH owns and operates the majority (68%) of all HC IV and hospital laboratories in Uganda. This number includes all the referral and RRH laboratories. PNFs are the second largest owners of laboratories in hospitals and HC IVs, operating 22% of them. The PHP sub-sector has limited market penetration at this level with only 10% ownership of labs operating in private hospitals and HC IVs. What is unclear is the number and extent of laboratories at lower levels and in smaller PHP facilities and whether they are functional.

Box 8.1 Lab Classification by Facility Levels

Laboratory Level 1 = HC II and HC III
 Laboratory Level 2 = General Hospital and HC IV
 Laboratory Level 3 = Regional and National Referral Hospital

Source: CPHL

Table 8.2 Public-Private Mix of Health Laboratories

Health Facility Level	Lab Level	Public ⁵¹	PNFP ⁵²	PHP ⁵³	Private %	Total
Referral Hospital	Level 3	2	0	0	0%	2
Regional Referral Hospital	Level 3	14	0	0	0%	14
General Hospital	Level 2	49	63	27	66%	139
HC IV	Level 2	182	17	7	12%	206
TOTAL		247 (68%)	80 (22%)	34 (10%)	32%	361
Stand Alone	Depends on scope	0	0	11	100%	11
Individual Clinicians with Labs ⁵⁴	Unclassified	0	0	Not available	Not available	Not available

Sources: AHSPR, 2014/2015; Medical Bureaus, and APHC Facility Registry; Detailed data for HC III not available

It is important to note that increased funding for HIV/AIDS response injected substantial sums of funding, equipment and supplies into the Uganda health system that not only helped strengthen the public laboratory capacity but also created a vertical laboratory program (Elbireer, 2012). In 2004, there were only about 502 health laboratories in government facilities throughout the public system. By 2007, this number increased 146% to 1,234 laboratories (Elbireer, 2012).

8.2.2 Types and Distribution of Private Laboratories

The range of private laboratory services are diverse and mirror the Ugandan health services levels, ranging from basic lab services in HC levels III and IV, to more complex ones in general and regional referral hospital and the national reference facilities. Figure 8.2 illustrates both public and private laboratories by facility level. One can see that most of the private laboratories – both PNFP and PHP – are concentrated in Levels 2 and 3. In addition, there is a large, yet unknown, number of individual private providers who have small labs in the clinics and doctor’s office and a growing, albeit small, number of stand-alone labs in Uganda. Although many private providers invest in purchasing a lab to help distinguish them in the market place, most of these labs quickly become non-functional because of the added expense to maintain the equipment as well as the high cost of re-supply of reagents. Finally, there is no official estimate of how many “quack” laboratories are in operation but they are a concern to the public and private sector alike. Similar to private health facilities, the labs in private hospitals and the stand-alone labs are concentrated in urban areas.

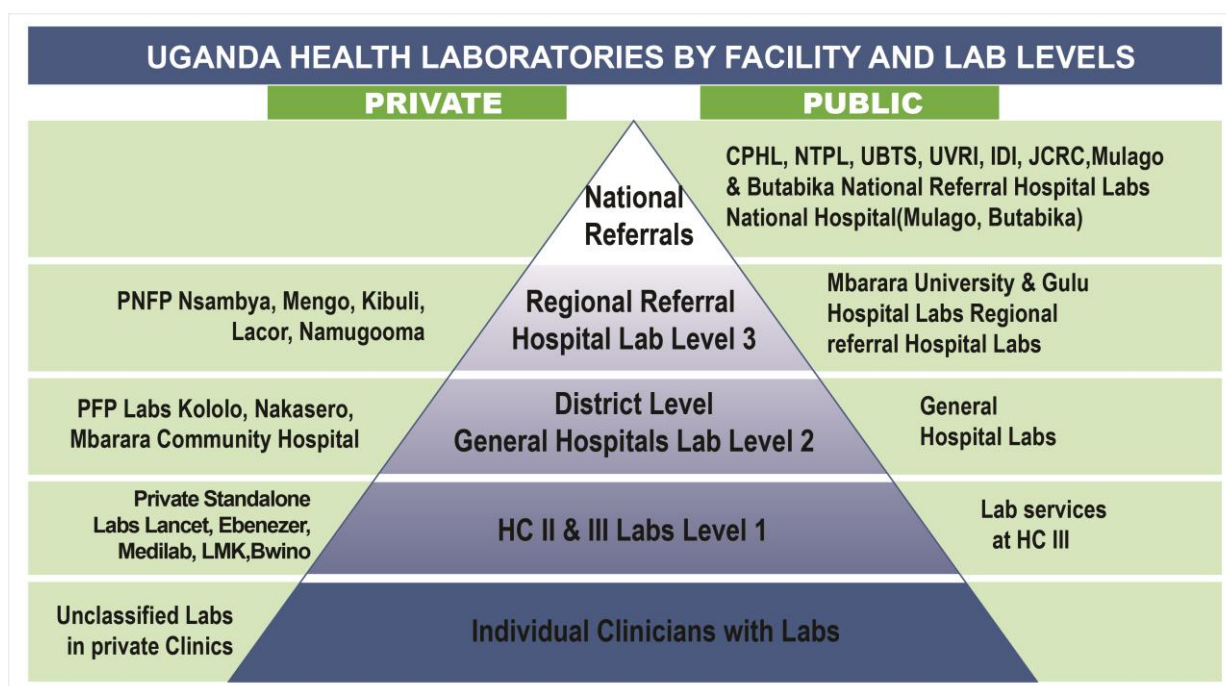
⁵¹ Data source on MoH laboratories is from the Annual Health Sector Performance Report, 2014/15.

⁵² Data source on PNFP laboratories is from medical bureaus service delivery statistics

⁵³ Data source on PFP laboratories is calculated from APHC facility registry

⁵⁴ There is no data on the actual number of labs in individual private provider practice

Figure 8.3 Uganda Health Laboratories by Facility and Laboratory Levels



8.2.3 Key Actors in Medical Laboratory Network

This section describes the diverse actors in the medical laboratory sub-sector and is organized by public, PNFP and PFP providers. As one will note, the PFP sector is still small in the medical lab market, unlike in Kenya and Tanzania.

8.2.4 Public Sector Health Laboratory Network

Size and geographic distribution of public health sector labs. Table 8.2 shows that the public sector manages the largest lab network for higher-level facilities in Uganda in terms of scope and number of labs. Over two thirds (69%) of all Ugandan labs are found in a public facilities. Given the public health nature of disease surveillance, blood bank management, and infectious disease control, it is more efficient for the public sector to invest in the central level medical laboratory centers (See next section). In addition, the public sector operates and runs the National Reference Hospital Labs at Mulago and Butabika National Reference Hospitals. The organization of the public laboratory network is described below.

Central Public Health Laboratories (CPHL). The CPHL is charged with the mandate to coordinate all health laboratory services and is located at the central level of the MOH unit under the Department of National Disease Control (NDC). Established in 1983 as a national reference laboratory to support the Epidemiological Surveillance Division (ESD) in disease surveillance and outbreak investigation, CPHL took up the role of coordination and stewardship of laboratory services in 1999 following a restructuring process at the MoH. CPHL activities focus mostly on public and PNFP labs.

National Reference Laboratories. At the central level, there are several different national reference laboratories including National TB Reference Laboratory (NTRL), Infectious Disease Institute (IDI), and National STI/STD Reference Laboratory. In addition, there are multiple agencies related to national health laboratory network such as Uganda Virus Research Institute (UVRI), Joint Clinical Research Center, Uganda Blood Transfusion Services (UBTS) and Key Departments at Makerere University.

National Referral Hospital Laboratories. Mulago Hospital complex and Butabika National Referral Hospital offer routine and specialized laboratory services and act as tertiary centers for lower facilities. However, they are both faced with challenges of commodities, equipment and human resource (NHLSP, 2010).

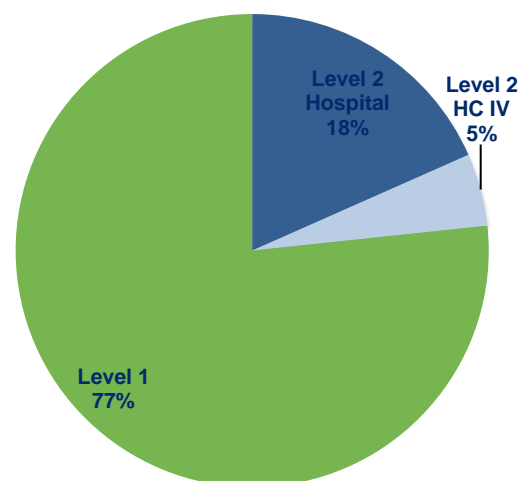
Regional Referral Hospital Laboratories. Below the National level, there are 14 regional referral hospitals (RRH); each has catchment area of ten to twelve districts or an equivalent of 2,000,000 people (Health Facility Inventory 2012). The laboratories at these RRH perform diagnostic testing in support of clinical services at the regional hospital, offer specialist and referral services within the respective regions, conduct training for health laboratory staff in collaboration with training institutions, maintain records for laboratory information and forward data to CPHL/HMIS, and coordinate National External Quality Assessment Service (NEQAS) activities related to **public labs** in the region.

District Level Laboratory Services. The MoH has forty-nine (49) general hospitals (GH) that provide general medical and surgical care. Each GH caters for two to three districts or an equivalent of population of 500,000 people (Health Facility Inventory 2012). The district authority manages the lab. Laboratories in these facilities provide microscopy, serology, routine chemistries and hematology. To ease running of these services, each district is divided into health sub-districts (HSD), which are at county level. Within the districts, laboratory services exist at HC IV (county level) and III (sub-county level).

Health Facility Levels. Of the almost 1,000 HC III in the public system, 60% have a laboratory (NHLSP Policy, 2010). However, a significant percentage of these labs are non-operational due to non-functional equipment and/or stock-out of key supplies.

Challenges. All lab services are free in public facilities except for those rendered in private wings in MoH hospitals. The MoH labs serve Ugandans of all socio-economic levels. The MoH struggles to keep up with demand due to inadequate numbers of trained HRH in lab professions, frequent stock-outs of key supplies such as reagents, and broken equipment (stakeholder interviews). Similar to the drug supply problems in the public sector, a large percentage of public sector clients are forced to get their lab services at a PNFP and PFP lab due to non-functional labs.

Figure 8.4 PNFP Labs by Level (N= 343)



Source: Medical Bureau Statistics

8.2.5 PNFP Health Laboratory Network

The CPHL oversees the PNFP health laboratory infrastructure. The PNFPs have the second largest health laboratory network, which is organized according to the Ugandan health service levels, ranging from basic lab services in HC levels III and IV, to general, and referral hospital laboratories. The PNFP sector also experienced rapid growth in laboratory services similar to the public sector due to PEPFAR funds.

Critical role of medical bureaus in PNFP lab operations. The medical bureaus play a network manager role for the laboratories located in their respective facilities, which in turn, helps the MoH oversee the PNFP labs. They fulfill key operations/ management functions such as staff management, facility upkeep, procurement of supplies, equipment purchases and maintenance, medical records and reporting to the MoH. In addition, the bureaus play a critical role in assuring quality by making sure: (i) all lab staff are certified, (ii) equipment is licensed, (iii) supplies are procured through reliable sources, and (iv) supportive supervision and site inspections are conducted on a regular basis.

The PNFP laboratories have benefited from their long-standing partnership with the MoH, which has in turn helped PNFP lab quality. The PNFP laboratory staff receive training, proficiency testing and supportive supervision visits from the MoH/DHOs.

Size and geographic distribution of PNFP labs. The PNFPs own and operate almost a third (29%) of all labs in Uganda. Of these labs, about 20% are located in urban and 80% in rural facilities. When examining the scope and capacity of PNFP labs, the majority (77%) are Level 1 (HC III) labs, followed by 18% are Level 2 labs in general hospitals, and 5% Level 2 labs in HC IV.

Source of equipment and supplies. PNFPs receive their laboratory supplies through different sources. Most PNFP labs procure their supplies from JMS or the open market. They procure from certified suppliers in Belgium, Germany, Kenya, South Africa and even Uganda (Elbireer, 2012). Development partners are another important source of quality supplies. PEPFAR and CDC donate supplies like HIV/AIDS test kits and reagents. PNFP facilities, which participate in a development partner program, can obtain supplies through the CPHL credit line.

Patient profiles. PNFP labs see a large volume of patients each year. According to 2016 data from UCMB, UPMB, UOMB, the four bureaus together conduct on average 3,177,856 lab procedures every year. The majority of the patients – particularly in urban areas are middle class and/or working poor. However, in rural areas the PNFP lab patients are predominantly poor. As expected, PNFPs see poorer clientele compared to PHPs (See Table 8.4). Since there is no public insurance and very few individuals have private insurance, the majority pay OOP for lab tests.

Challenges. PNFP labs confront several operational constraints (See Table 8.4). First, although the government and development partners subsidize the cost of supplies, PNFP medical labs are unable to cover all their costs because of their clients’ inability to pay. Secondly, PNFP need capital, which they cannot raise from commercial lenders, to purchase and repair lab equipment as well as to serve as a cash buffer for the cost of reagents because the nature of their business is “not for profit” and this makes it hard for them to pay back loans. Thirdly, PNFPs interviewed reported high staff turnover mainly to the public sector because of better salary, better working conditions like reduced workload, training programs and CPD benefits. PNFPs further reported that despite having many very highly qualified staff, many are not supported in the government placement arrangements. Some of the PNFPs reported that government supported PNFP staff had left and their positions had not been filled. Finally, recruitment and retention of qualified lab staff is a challenge, because incomes are not sufficient to recover their costs.

Table 8.4 Challenges Confronting PNFP and PFP Medical Labs n=32

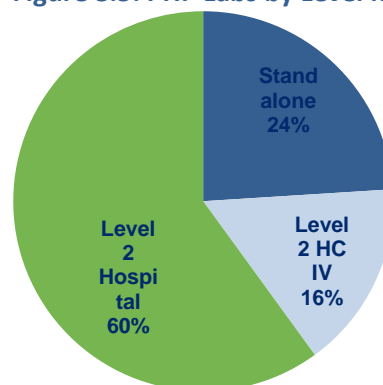
Ownership	Clients unable to pay %	Cost of Supplies	Access to Capital	Recruit/Retain Qualified Staff
PHP	27%	20%	53%	0%
PNFP	50%	0%	38%	12%
Overall	35%	13%	48%	4%

Source: PSA Stakeholder interviews 2016

8.2.6 PHP Health Laboratories

Size and geographic distribution of PHP labs. Among the 45 PHP labs sampled for the PSA, the majority (60%) are Level 2 and are located in private hospitals, which are concentrated in Kampala and other urban centers. The scope in the stand-alone lab ranges from Level 1 to Level 3 (Figure 8.5). Many of the private hospitals and clinics have developed their diagnostic and imaging centers in partnership with Indian and South African partners. South Africa is close enough to send lab tests (and patients) back and forth while India has the advantage of relatively advanced healthcare to support the labs. Twenty-four percent (24%) of all PFP labs are stand-alone labs

Figure 8.5: PHP Labs by Level n=45



Source: APHC Facility Register, 2016

Profile of patients served by PHP Labs. All PHP lab owners reported that they serve clients from all socio-economic groups. For stand-alone labs, there is an even split between walk-ins compared to doctor-referred clients. Most walk-in clients come from public facilities, which do not have lab capacity (mostly due to stock-out or broken equipment). Key reasons cited why clients go to a PHP lab include:

- Convenience – many are located in popular areas in urban centers;
- Longer working hours – PHP labs are open for longer hours – minimum 12 hours per day (some up to 24 hours) and more days - several are 24/7 service providers;
- Quick service – many private lab owners cited that for common lab procedures, they could turn around test results in less than three hours; and
- Public sector labs not functional.

The majority of clients pay cash for the lab services (PSA stakeholder interviews, 2016). A low percentage (10% to 20%) has some form of private health insurance although many complained about late payment by insurance companies and their attempts to reimburse at low margins. A few lab owners interviewed reported that they offer flexible payment terms for the poor who cannot pay the entire cost upfront. The PSA Team sampled 45 PNFP and PFP labs and found that PHPs served more middle and upper-income patients, particularly when compared to PNFP laboratories (See Table 8.5).

Table 8.5 Distribution of Lab Clients in Private Provider Labs by Income Group

Income Group/ Type of Provider	PFP	PNFP	Total
Low Income	45%	67%	53%
Middle/Upper Income	55%	33%	47%
Total	100%	100%	100.00%

Source: PSA stakeholder interviews analyzed using Linkert Scale

Challenges. Except for labs in private hospitals or the few stand-alone labs owned by international organizations, the small, individual lab owners struggle to cover operating costs. Although they would like to expand, market conditions are difficult. Client volume is low. Small private stand-alone labs average only five clients per day while larger ones see upwards of fifty and these labs cannot charge “true” market prices because the majority of clients pay OOP, many of who are poor and shop around for the best price. With low volume and low prices, the stand-alone labs find themselves with over-capacity and minimal revenue flow.

The medical lab profession is also experiencing HRH shortages. Uganda does not produce sufficient number of HRH to meet the demand for lab services. Recruiting and retaining qualified staff is a perennial problem for private medical laboratories. Many private owners stated they want to invest in continuing education of their staff but struggle to retain them because many leave to work in the public sector as salaries are comparable to those in the private sector but the benefits are greater.

The biggest cost driver for expansion is equipment (buying and repairing). Like PNFP facility owners, access to capital is difficult (see Table 8.4). Many are willing to borrow from commercial banks but the interest rates are too high. Many owners interviewed also stated they lack the business and financial management skills needed to manage their businesses efficiently.

8.2.7 Development Partners Supporting the Health Laboratory System

Development partners, in particular those from the USG, have influenced the medical laboratory sub-sector in Uganda. Through PEPFAR, the USG supports Uganda health sector in the areas of HIV/AIDS and TB and focuses on infrastructural improvements in health facilities and the laboratories. A key objective of PEPFAR is *“to strengthen the provision, coordination and management of comprehensive health laboratory services and increase adherence to norms and standards by expanding accreditation of service delivery points labs”*⁵⁵ In 2009, PEPFAR dedicated \$1.0 to \$1.4 billion to supporting health systems, of which 6% was earmarked for strengthening laboratory systems.⁵⁶

PEPFAR funds have enhanced the coverage of essential PMTCT lab services, expanded an established transport network for lab samples, created a regional transport hub, and developed point-of-care CD4 testing in hard-to-reach districts where the transport network is not functional.

- Examples of PEPFAR support include the CDC-funded (US\$7million or UGX 18 billion) construction of the national health laboratory at Butabika. The laboratory is a major leap forward in handling highly infectious pathogens⁵⁷.
- Becton, Dickinson and Company (BDC), a medical technology company offers Laboratory Quality Management Training for all labs performing CD4 testing. BDC helped develop a specimen referral system, using Global Positioning System/Geographic Information System (GPS/GIS) to map multiple laboratory sites for development of a transportation network and to monitor specific improvements in the laboratories⁵⁸.
- In 2013, PEPFAR provided financial support to recruit and pay for health workers for 87 districts for public and PNFP health facilities particularly general hospitals and HCII.⁵⁹ Medical lab staff was part of this recruitment initiative.

The World Bank-funded [East Africa Public Health Laboratory Networking Project \(EAPHLNP\)](#) aims to establish a *network of laboratories to improve access to diagnostic services for vulnerable populations and strengthen disease outbreak preparedness* in the EAC countries. The EAPHLNP’s objective is to establish a network of efficient, high quality, accessible public health laboratories for the diagnosis and surveillance of TB, and other communicable diseases. There are three components to the project; the first component is a regional diagnostic and surveillance capacity. This component led by Uganda, working in close collaboration with ECSA Health Community will provide targeted support to create and render functional the regional laboratory network. The second component is the joint training and capacity building. The project will support training in a range of institutions in the four countries and across the region.

⁵⁵ <http://www.pepfar.gov/documents/organization/199589.pdf>

⁵⁶ Ibid

⁵⁷ New Vision 23rd July 2013

⁵⁸ <http://www.cdc.gov/globalaids/Success-Stories/BD-Public-PrivatePartnership.html>

⁵⁹ Guidelines for USG/PEPFAR support to recruitment of health workers to enhance HIV/AIDS service coverage 2015

Tanzania leads this effort. The third component is joint operational research and knowledge sharing; this component supports relevant operational research, knowledge sharing/management, regional coordination and program management.

8.2.8 Laboratory HRH

Getting current numbers of HRH working in this sub-sector was challenging. MoH lumps the different cadres as “lab staff” while even some bureaus did not have data on their lab staff save for UCMB and UOMB. There was significant improvement in staffing levels nationally between 2012 and 2014, because of the recruitment efforts by both government and development partners. By April 2015, the national staffing situation for lab personnel was 2,379 positions of the norm of 2737 (87%) filled and further support was planned for 2016.

8.3. Price Comparison between PNFP and PHP Lab Services

Diagnostic laboratory tests are routinely defined in terms of their sensitivity, specificity, and ease of use. Nevertheless, the actual clinical impact of a diagnostic test also depends on its availability and price. While many of the respondents in PHPs said that lab test prices are similar with those in PNFPs, Table 8.6 indicates that PHP prices were much higher than PNFP prices. Prices in PFP labs were, on average, almost double the prices found in PNFP ones. In some areas, such as clinical chemistry PFP prices are two to six times higher and in immunochemistry, four times higher. Moreover, the PNFP labs did not charge clients for many routine tests such as pregnancy, urine and stool analysis. It is interesting to note that both PNFP and PFP labs do not charge for viral load tests.

Table 8.6 Median Prices for Top Five Tests in PFP and PNFP Labs

Key Tests performed	Price in PFP	Price in PNFP
Clinical Chemistry		
1.RBS/Fasting blood sugars	5,000	3,500
2.Liver functioning Test (LFT)	64,000	10,000
3.Renal function test	25,000	10,000
4.Lipid profiles	34,000	NA
5.Cardiac test	35,000	NA
Immunochemistry		
1.CD4	14,300	3,000
2.Serum tests	12,500	NA
Hematology/Malaria		
1.B/S	3,000	1,000
2.Hemoglobin estatratum	4,000	2,500
3.Blood grouping	3,500	3,000
4.Erythrocyte sedimentation (ESR)	5,000	2,500
5.Sickling test	5,000	2,000
Microbiology (Parasitology/Bacteriology)		
1.Urine analysis	5,000	3000
2.Stool analysis	4,000	4,000
3.ZN	6,500	2,500
4.Gram staining	6,000	4,000
5.CBC	15,000	15,000
Serology		
1.HIV test	+5,000	++3,500
2.TPHA/WIDAL	5,000	3,000
3.RPR test	5,000	3,000

Key Tests performed	Price in PFP	Price in PNFP
4.Pregnancy test	5,000	2,500
5.Hepatitis test	10,000	5,000
6.Bat	5,000	7,000
Viral Load		
31% said they offered viral load tests	Free	Free
+ 35% of PFP sites offered HIV test for free	++60% of PNFP sites offer HIV test for free	

Source: PSA Facility Assessment, 2016

8.4. Key Challenges to Laboratory Sub-sector

Elbireer describes common challenges found in health laboratory systems found in SSA (Elbireer, 2012). At the national level, challenges include weak regulatory agencies, and poor enforcement. At the service delivery level, challenges range from old infrastructure, out-of-date or non-functional equipment, constant stock-outs of supplies, insufficient HRH and inadequate training of HR in the laboratory profession. As the following discussion highlights, the Uganda laboratory sub-sector also faces many of the same challenges.

8.4.1 Weak Governance and Management of the Medical Lab Sub-Sector

Although there is a policy and regulatory framework in place to govern the medical laboratory sub-sector, implementation is weak. Laboratory outcomes are directly linked to capable leadership and administration of the sub-sector (Elbireer, 2012). In the Ugandan health system, there is no single coordinating body responsible for laboratory services. Instead, there are three government agencies - AHPC, CPHL and NDA – that carry out regulatory functions but the roles and responsibilities between agencies are not well defined and are confusing (NHLS Policy, 2009).

In addition, the existing regulatory bodies are weak and not effectively carrying out their duties. For example, the AHPC is charged with registering all laboratory practitioners and laboratories. The Council struggles to fulfill this role because they are understaffed. Also, the majority of the private laboratories are linked to private providers who register them with the UMDPC. According to media reports, only thirty percent (30%) of labs in Uganda are licensed.⁶⁰ Moreover, stakeholders interviewed indicated that dual practice is not effectively regulated between public and private laboratory staff and facilities. Given the fragmentation between AHPC and CPHL, these providers slip through the cracks.

Insufficient Data to Manage Non-State Providers. The MoH lacks the data needed to manage and oversee the entire laboratory sub-sector. First, data on number of licensed laboratories and registered HRH are not in a single depository but instead located in multiple sources, making it difficult for rational planning and management of laboratory infrastructure, HRH and equipment across the public, PNFP and PHP laboratory networks. Second, data on disease surveillance and infectious disease control are underestimates. According to the NHLS Policy 2010, there are no mechanisms for PFP laboratories to report to the National Laboratory Management Information system.

Barriers to Market Entry Too Low. Several PSA stakeholders revealed that it is too easy for anyone to open up a laboratory facility, as evidenced by the significant number of unlicensed facilities noted in the 2013 Laboratory Survey. As a result, there are several “quack” labs staffed with unqualified health professionals. Many of these rogue laboratories operate in tiny crowded rooms and in some cases, lack even basic equipment like a microscope. In a media survey of quack labs the Monitor Newspaper reported that most

⁶⁰ New Vision 15th June 2015

laboratories in Kampala were housed in tiny rooms, smaller than eight by 10 feet, and the testing area could hardly accommodate a microscope and the person operating it.⁶¹ In one facility, needle caps and blades were not disposed of properly (lying on the floor), while heaps of both infectious and non-infectious garbage gave off a foul smell outside one of the facilities.⁶²

Weak Enforcement of Quality Standards. In addition to unqualified staff, there is no guarantee of the quality of the medical equipment and test kits used. The problem of unsafe test kits has become more acute with the increased demand for HIV/AIDS testing. Some informants reported that there are no regulations in place to validate medical equipment and test kits allowing these rogue labs in Kampala to import and use test kits from any source, calling into question the quality of the tests.

Unscrupulous Practices. In April 2014, BBC News Africa reported that the selling of fake HIV-negative certificates has become a widespread practice in Uganda. A British Broadcasting Corporation Africa undercover investigation of 15 small private clinics identified 12 that were willing to sell a fake certificate with the clinic's official stamp and the health worker's signature for as little as US \$20. HIV-positive people purchased the fake HIV-negative results to get a job, travel abroad, or deceive a sexual partner about their status.⁶³ The Monitor newspaper also reported that cases of altering results were on the increase and reported cases in Luwero and Mukono where nurses were arrested for issuing fake HIV results to patients. The results were usually changed from a positive to negative status for money.

8.4.2 Uneven Quality of Laboratory Services

One can find the best and the worst quality in both the public and private sectors. In 2014, the second Scientific Conference of the African Society for Laboratory Medicine recognized three Ugandan laboratories for exhibiting the best medical laboratory practices in Africa: CPHL, UVRI, and NTRL were awarded certificates by the International Accreditation Society at this same conference.⁶⁴

Quality varies across the supply of laboratory services. Many of the public facilities were built several decades ago, are dilapidated and do not meet recommended standards. The National Laboratory Assessment Survey in 2009 revealed that: only 38% had the required staff; many labs were in poor physical state with less than 60% meeting requirements for ventilation, space and plumbing; and most labs were inadequately equipped with less than 40% meeting the national recommendations for their scope of practice. Also there is widespread lack of reliable sources of water and power, which affects public laboratories ability for safe waste disposal and infection control (NHLSP, 2009). Almost ten years later, quality still remains a challenge. In 2013, a study team conducted a quality survey of 954 public, PNFP and PFP clinical laboratories in Kampala using the WHO/AFRO-Star Rating (Elbireer et al, 2013⁶⁵). Only 4.7% of the 954 laboratories in Kampala city met the lowest quality standard (1-Star) of the modified WHO-AFRO laboratory-strengthening instrument and only 5% of the laboratories met or surpassed the 1-Star rating (see Table 8.7).

⁶¹ Saturday Monitor, 2013

⁶² New Vision, 2015

⁶³ <http://www.bbc.com/news/world-africa-26859087>

⁶⁴ East African Business Week Sunday, January 11, 2015

⁶⁵ Elbireer AM, Jackson JB, Sendagire H, Opiyo A, Bagenda D, et al. (2013) The Good, the Bad, and the Unknown: Quality of Clinical Laboratories in Kampala, Uganda. PLoS ONE 8(5): e64661. doi:10.1371/journal.pone.0064661

The PSA Team explored the relationship between quality rating and public-private sector ownership and found that public sector laboratory facilities ranked consistently higher, followed by PNFPs. A very low percentage (1%) had a quality score of 1 or above. It is interesting to note that 72% of the 954 laboratories were not registered with the MoH. Similarly, the PSA Team noted that most of the private laboratories in the PSA sample were neither registered nor regulated.

Table 8.7 Quality Ratings by Score (# of Stars)

Median No of Daily Tests	% of Labs	No of Stars
5	95.3%	0
20	1.5%	1
100	1.5%	2
200	0.7%	3
140	0.6%	4
200	0.4%	5

Source: Elbireer et al, 2013

Table 8.8 Laboratory Quality Ratings by Ownership

No. of Stars	Academic	Public	PNFP	PHP	Total
0 - Star	2	7	10	890	909
1 – 5 Stars	0	16	4	25	45
Total	2	23	14	915	954

Source: Elbireer et al, 2013

In a 2016 census of KCCA facilities,⁶⁶ 81% of the private health facilities with laboratories did not have laboratory certificates (see Table 8.9). In Central Division, 54% of the private health facilities had laboratory certificates, but in Kawempe, Makindye, Nakawa and Lubaga, less than 25% of the private health facilities with laboratories had laboratory certificates.

Table 8.9 Certification Status of KCCA Facilities with Laboratories by Division (N=1,075)

Lab Certificate Availability	Central	Kawempe	Makindye	Nakawa	Lubaga	Overall
Available	60 (54%)	48 (22%)	19 (6%)	36 (17%)	38 (18%)	201 (19%)
Not available	51 (46%)	174 (78%)	302 (94%)	173 (83%)	174 (82%)	874 (81%)
Total	111 (100%)	222 (100%)	321 (100%)	209 (100%)	212 (100%)	1,075 (100%)

Source: KCCA Census findings, 2016

Similarly, the majority of facilities (67%) of the 210 facilities with imaging and radiology service were not registered with the atomic energy council for imaging and radiology (see Table 8.10). Almost half (49%) of the health facilities that provided radiology and imaging services in Central Division were registered with the atomic energy council, while 43% in Nakawa Division and less than 40% in Kawempe, Makindye and Lubaga were registered.

⁶⁶ USAID/PHS Program, 2016. KCCA Facility Census 2016.

Table 8.10 Registration Status of KCCA Facilities with Imaging/Radiology Services by Division (N=212)

Registration status	Kampala Central	Kawempe	Makindye	Nakawa	Lubaga	Overall
Registered	20 (49%)	18 (38%)	8 (16%)	17 (43%)	7 (21%)	70 (33%)
Not registered	21 (51%)	29 (62%)	42 (84%)	23 (57%)	27 (79%)	142 (67%)
Total	41 (100%)	47 (100%)	50 (100%)	40 (100%)	34 (100%)	212 (100%)

Source: KCCA Census findings, 2016

The main determinants of quality in a setting like Uganda with weak regulatory capacity appears to be laboratory size and staff training (Elbireer et al, 2013). Higher-quality laboratories were, on average, larger and had a higher number of laboratory-specific staff (e.g. technologists, phlebotomists) than the other laboratories. They also performed a higher median average of tests per day. Larger laboratories, usually public, had higher quality scores than private laboratories. This relationship between laboratory quality and laboratory size is similar to what has been seen in other countries prior to the advent of laboratory regulations. The Elbireer 2013 study also noted that higher quality in public laboratories could be attributed to the financial resources given to the public sector by international donors for strengthening national laboratory systems in SSA including Uganda (Elbireer et al, 2013).

8.4.3 Laboratory HRH Challenges

Stakeholders interviewed stated there are two problems related to HRH. There are very few trained pathologists in the country despite government efforts to recruit and retain this cadre of professionals, with funding from PEPFAR, to fill the gaps. The National Lab Assessment Survey (MoH, 2004) noted that Laboratory Assistants were the most common staff (412), followed by Microscopists (204) and Technicians (171). Further, the lack of medical lab professionals as detailed below creates a patchwork of staffing at public facilities that fall short of clinical guidelines, raising concerns of the quality of lab tests in public facilities:

- Forty percent (40%) of HC III did not have a lab staff above the level of laboratory attendant;
- Twenty-nine percent (29%) of HC III were staffed with only one or more attendant and one or more microscopists; and
- Seventy percent (70%) of district hospitals did not have a technologist.

According to stakeholder interviews, this staffing pattern persists today in Uganda. Due to the HRH shortage, there is intense competition for the small pool of qualified licensed staff. Human resources in the public laboratory sector are viewed as being better trained than their counterparts in the PNFs and PHP especially since lab professionals in the public sector benefit from donor training. Given the low profit margins on lab tests, PHPs struggle to recruit and retain highly qualified staff. Many PNF and PHP labs employ mostly low cadres, such as laboratory assistants and in a few cases lab technicians, which can also compromise quality. Moreover, there are limited opportunities for continuing education for the staff. There is constant “churning” in medical lab staff – most leaving the PFP sector to seek employment in the public and PNF sectors because of better benefits, continuing education and scholarship opportunities, which are all funded by donors.

Another consequence of HRH shortages is unlicensed staff filling lab positions. The 2004 National Laboratory Assessment Survey noted that one-third of laboratory personnel were essentially working illegally – lab attendants and microscopists are not recognized as lab personnel.

This practice persists today as revealed by continuous media exposés on the status of quality in private labs.

8.4.4 Irrational Use of Laboratory Infrastructure

Similar to the Maternal and RH sub sector, there is an inefficient use of existing medical laboratory infrastructure in Uganda. There is high demand and overcrowding of public laboratory facilities. Public laboratories at the national and reference hospital labs have the latest technology and equipment, in large part because of development partner funding, and are well equipped to handle complex lab analysis and diagnosis. In most cases, PHPs do not access public referral labs and have to send complicated tests to Kenya or South Africa yet there is capacity in-country.

On the other hand, the majority of the public labs are old and/or have inoperable equipment because they are broken and experience persistent stock-outs of reagents, yet there is under-utilized capacity in the private sector – particularly the formal, licensed PFP sector. Demand is low in the PHPs due to prices of lab tests. Licensed PHPs, in contrast to public laboratories, have state-of-the-art equipment given their facility scope of practice, the equipment is always operable, and they have a steady supply of reagents. They also procure all their equipment and supplies through pre-qualified and recognized distributors ensuring quality of both. But there is no mechanism – and in some instances as stakeholders also noted no interest in exploring strategies to harmonize the laboratory infrastructure between public and private labs.

Figure 8.5 Irrational Use of Laboratory Infrastructure

Public Sector

- High demand at facilities
- Latest technology & equipment
- Equipment often inoperable
- Persistent stock-outs of reagents

→ *Highly inefficient*



Private Sector

- High demand in PNFPs
- Over capacity in PHPs
- Equipment always operable
- Constant supply of reagents
- Unable to perform complicated tests

→ *Underutilized capacity*

8.4.5 MoH Reluctance to Partner with the PFP

The health laboratory sub-sector is slow to embrace PPPs (EAPHLNP, 2014). Although the MoH has signed a MOU with the FBOs umbrella organizations to deliver health and limited laboratory services, there has been limited interaction and engagement between the MoH and licensed PFP. The PFP stakeholders interviewed expressed keen interest in partnering with the MOH but given the multiple agencies involved in laboratory services, they do not know who to approach. Moreover, the few interactions they have had have not resulted in any concrete activities. Many expressed a desire for a platform or a mechanism to dialogue and interact with the MOH to discuss issues common to public and private sector providers in this sub-sector – such as proliferation of “quack” labs – and to identify opportunities for coordination and partnerships.

“There is need for a platform for dialogue between private sector and govt. Some of us have engaged government informally but have not achieved much. For example, the Mulago CT scan is always down – this a potential area of collaboration with nearby private facilities that have CT scan.”

Key informant in Kampala

TAKE HOME MESSAGES ON PRIVATE LABORATORIES

- There are important policy gaps regulating non-state medical laboratories. Entry to market is too easy, allowing too many “quack” labs to operate side by side with licensed laboratories. There is no clear and coordinated system to assure quality in the lab sector, allowing for unscrupulous practices. And the sector is missing key policies, such as sourcing for tests from credited suppliers.
- There is a reason why the PFP lab sector is small compared to other East African countries: market conditions are challenging. Costs for inputs are high and prices are artificially low compared to other markets. PFP labs experience difficulty in accessing capital to purchase equipment and/or expand unless they are a subsidiary of a regional laboratory company. PFP labs struggle to survive – their strategy is to further cut prices to drive volume, creating further downward pressure on prices.
- Currently there is no tax exemption or relief for PFP labs performing HIV and other important tests.
- Quality is still a problem in PFP labs, particularly with small labs located in private provider facilities and/or small, stand-alone labs. Some of the more modern labs, such as Lancet and Path, follow ISO standards.
- Compared to the private sector in supply chain, the lab sector is disorganized and fragmented. The professional associations are not as mature and well established as those in the pharma sector. And there is no platform to share information and lobby for the sector’s interests with government. Until the development of the National Laboratory Strategic Plan, there has been almost no interaction between MOH and private sector labs. There has been minimal dialogue since.
- MOH officials governing the lab sector are slow to embrace working with the private sector and PPPs. Few are aware of the PPPH Policy and/or regional experience in public-private collaboration in this sub-sector.
- Despite the challenges, the private sector is optimistic about growth in the lab sector. All private sector stakeholders interviewed expressed keen interest in working more closely with the government in policy design and planning for this sub-sector and in partnering with the government to help address challenges found in MOH labs.
- There are successful examples in the region of public-private collaboration in the lab sub-sector that are transferable to the Ugandan setting.

8.4.6 Difficult Market Conditions

Like PFP health providers, PFP lab owners find market conditions difficult and this limits their ability to expand. The costs for inputs are high and the government does not offer any tax exemptions or relief for key tests that have a public health benefit. Moreover, PFP lab owners also have limited access to affordable financing to replace their aging equipment and/or expand services. Many owners interviewed are willing to borrow from commercial banks but the interest rates are too high. In addition, the collateral requirements are steep and they fear losing their business. As a result, they struggle to survive and the only viable strategy is to cut prices further to drive volume.

8.5. Recommendations

There is increasing demand for diagnostic centers and laboratories in Uganda. In response, there has been a rise in the number of smaller clinics offering diagnostics and laboratory services, but consumers are also voicing a need for “one-stop-shop” diagnostic centers. The team recommends the following to help grow private sector contribution in relieving congestion in public labs and creating access to affordable diagnostics.

“It would be great if the many small facilities came together to form something similar to doctor’s plaza in Nairobi. This would not only reduce duplication and improve services but would even reduce costs to the facilities by sharing personnel and space etc.”

Key informant in Kampala

Streamline and modernize the regulatory system. Similar to the pharmaceutical sector, there are multiple agencies, in this case three (AHPC, CPHL and NDA), responsible for regulating the medical laboratory sub-sector. Reducing the number of agencies and clarifying their roles and responsibilities vis-à-vis other related bodies is a first step. Key among the roles to be clarified is the need to determine which agency is responsible for registering all labs, irrespective of whether they are in hospitals, clinics or medical offices. Secondly, the MOH needs to invest in building the designated agency's capacity, including staff and budget. Thirdly, the regulatory agency responsible for labs also needs to modernize its system, including collecting and centralizing the data needed to regulate both public and private laboratories effectively.

- 1. Strengthen MoH capacity to assure quality.** The MoH also needs to invest in strengthening the lab quality assurance system similar to the one monitoring quality for health services. Tasks include: conducting a review of existing clinical standards to determine if they meet current best practices; establishing universal standards that apply to both public and private medical laboratories, and; investing in a system and staff to monitor quality standards across all public, PNFP and PHP laboratories.
- 2. Promote greater interaction and dialogue.** Many PNFP and PHP laboratory managers and owners expressed the need for more frequent communication and interactions on issues confronting the sub-sector. Many PHP lab owners/operators expressed an interest in sharing new technologies and innovations with the public sector as well as working together to address sector wide issues such as access and quality.
- 3. Establish a Referral/Counter-Referral System.** A simple, low risk collaboration between the public and private sector is to develop a comprehensive directory of all public and private laboratories. The AHPC recently conducted an inventory of all private laboratories, which could serve as the starting point for this exercise. The CPHL could convene a forum for all relevant MOH entities along with medical bureaus and PFP laboratory managers to work together. The directory includes name, address, location, operating hours, range of services, number and type of staff, and number and type of equipment. This type of collaboration often generates other ideas on how to work together, as was the case in Tanzania (see Box 8.2).

Box 8.2 Public-Private Collaboration in Tanzania

The Tanzanian MOHSW PPP Node worked with the Medical and Laboratory Scientists Association to develop an online directory of labs and diagnostic centers. Laboratory providers can add their information online and patients can search for lab services by visiting <http://labs.melsat.or.tz>.

The public-private collaboration identified and promoted other opportunities for collaboration:

- Identified referral opportunities between public and private labs
 - MOHSW now contracts with and NHIS reimburses private labs for specific lab tests at a negotiated rate
 - Private labs refer and pay for specialty tests conducted at MOH referral labs
- Also private labs “lend” reagents during stock-outs or repair MOH lab equipment

(Source: <http://shopsproject.org/resource-center/public-private-partnership-to-expand-the-reach-of-medical-laboratory-services>)



4. **Co-locate a PHP lab in public or PNFP facility.** According to stakeholders interviewed, MOH has expressed interest in partnering with the private sector to equip and train public sector staff in detection of communicable and non-communicable disease. One possible partnership arrangement – co-location – has been successfully implemented in Kenya (see Box 8.3). The MOH can identify one to two public or PNFP hospitals with under-performing lab units and assess whether a co-location partnership is viable. In addition, PPPH Node staff can visit Moi Hospital and LANCET to understand the principles and structure of the co-location contract, reimbursement levels and payment terms better.

Box 8.3 Public-Private Collaboration in Kenya

LANCET approached the Director of Moi Hospital, district-level government hospital in South Eastern Kenya, take over management of its laboratory. LANCET and the Moi Hospital Director, with the District Health Officer's approval, signed a contract permitting LANCET to co-locate its operations in a government facility.



Under this arrangement, LANCET was responsible for assuming all operations of the Hospital's lab which included rehabilitating the lab space, purchasing all new state-of-the-art equipment, adding additional staff to meet projected demand, covering all operating costs including reagents and assuring quality. LANCET also paid rent for space in Moi Hospital. In addition to adding staff, LANCET trained MOH lab staff as well as Moi Hospital staff in how to analyse test results. In exchange, the government guaranteed a certain volume of tests at a negotiated rate that was below market. Moi Hospital reimbursed LANCET for on a unit cost-for-service.

The co-location partnership produced positive results for both partners. For Moi Hospital, for the first time in many years that have a fully functioning lab with modern equipment that now offers a wider range of tests than before, their lab and medical staff are trained in how to interpret the test results which have led to better diagnosis. new diagnostic technologies. LANCET, through volume, has been able to not only recuperate its costs but has also earned significant profit; so much so they are now sharing a percentage with MOI Hospital. And the consumers are now able to conveniently obtain their lab tests with rapid results at an affordable price.

(Source: <http://shopsproject.org/resource-center/public-private-partnership-to-expand-the-reach-of-medical-laboratory-services>)

9. PUBLIC-PRIVATE MIX IN HUMAN RESOURCES FOR HEALTH

An effective health system needs a qualified and accessible health workforce that can provide quality health services to all. Without this backbone of skilled human resources in health, a country like Uganda will not be able to achieve universal health coverage (Oketcho et al, 2015). To ensure everyone has access to a competent health worker – no matter which sector they work in – the MoH must examine both public and private sector workforce **together** in order to better align and leverage them both. Moreover, the MoH needs to acknowledge in its policy and planning design, that a change in one sector can have a direct impact on the other. This section begins the process of better understanding the symbiotic relationship between the public, PNFP and PHP health work force.



9.1. Governance and Management of HRH

There are two key functions that MoH plays related to HRH. First, sector-wide planning to assure a sufficient number of skilled and well-trained HRH with the range and type of HRH cadres needed given the disease burden in the country and their equitable distribution. This type of planning encompasses all HRH – public and private, including PHP. The second and very different role is management of its own staff. Like a major corporation with thousands of employees, the MoH needs to have strong policies and systems in place to carry out basic HRH functions to manage its own workforce. However, in developing countries with a long tradition of public-sector oriented health delivery, these functions are blurred, often resulting in the first role being confused with the second. As part of workforce planning and health sector stewardship, the MoH can play a strategic role in managing healthcare labor markets to ensure balance among the public and private sector workforce as well as the incentives needed to retain HRH in the health professionals practicing in Uganda.

9.2. HRH Workforce Stewardship and Planning

Stewardship. The MoH has several of the policies and government apparatus needed to “set the rules” of the healthcare profession in Uganda. As Table 9.1 illustrates, the institutional arrangement governing the healthcare profession in Uganda involves not only the MoH and its regulatory bodies but also four other government ministries. According to a MoH 2007 report,⁶⁷ this multiplicity of stakeholders makes HRH planning and decision-making processes long, often frustrating and sometimes ineffective.

⁶⁷ MoH, 2007. Uganda Health Workforce Study: Satisfaction and Intent to Stay Among Current Health Workers.

Planning. Effective HRH planning relies on accurate data and professional leadership (CAPACITY Project, 2015). The MoH has made great strides in HRH planning with the introduction and use of the HR Information Systems (HRIS), which has helped the MoH move towards more data driven planning. However, the HRIS only collects and analyses data on public and PNFP HRH and is used to manage and plan for these two sectors only. An important gap is a basic understanding and data on the PHP workforce, which according to current data represent 35% of the total HRH in Uganda (see Section 2). More can be done to integrate PHPs, thereby moving MoH to more inclusive sector-wide planning. Integrating data on number of HRH working in the private sector as well as other information on staff turn-over and compensation will help the MoH better understand the interaction between public and private HRH labor markets.

Table 9.1: Governance structure for HRH

Ministry	Responsibility	Affiliate Organization
Ministry of Health / Professional Councils	Regulation of health workers' professional standards and ethics. Assurance that all health workers maintain relevant licensure	Uganda Medical and Dental Practitioner's Council; Uganda Allied Health Council; Uganda Nurses' and Midwives' Council; Pharmacy Council.
Ministry of Education and Sports	Professional training of health workers	Examination boards: Uganda National Examination Board (UNEB), Uganda Nurses and Midwives Examination Board (UNMEB), Allied Health Examination Board (AHEB).
Ministry of Public Service	Central-level human resources employment policies, strategies, and management	Public Service Commission
Ministry of Finance, Planning and Economic Development	Health workforce financing and budget allocations	National Planning Authority; Uganda Bureau of Statistics; Population Secretariat.
Ministry of Local Government	District-level recruitment, deployment, supervision of staff Payroll management of MoH health workers.	District Service Commission Local Government boards

9.2.1 HRH Management and Development

The fragmented approach to HRH management greatly affects quality of services delivered in the public sector (CAPACITY Project, 2008). A 2003 World Bank assessment in Uganda revealed that the HRH managers in the public sector have limited or no authority in key personnel functions such as setting salary levels, determining and implementing disciplinary approaches, recruitment and promotions and establishing career paths.⁶⁸ In addition, Uganda's public health system suffers from dual management; urban facilities and tertiary hospitals are managed centrally by the MoH, while general hospitals and HCs II, III, and IV are managed by district/local governments.

⁶⁸ World Bank, 2003. Health Care on the Frontlines: Survey Evidence on Public and Private Providers in Uganda.

HRH management also affects the quality of health services delivered in the private sector. However PNFP and PHP facilities are not subject to the same HRH policies and procedures as public facilities and have more flexibility and tools to manage their workforce. Increasingly, the PNFP medical bureaus have assumed the important function of HRH management for the entire workforce in their network of facilities. Although the bureaus still face considerable challenges in this role (e.g. recruitment and retention), they have made great strides in putting into place the HR policies and procedures to plan, recruit and manage the more than 7,000 staff employed in PNFP facilities.⁶⁹ Stakeholders interviewed considered the PNFP HRH management to be more agile and responsive when compared to the public sector. In the case of PHPs, the more modern, sophisticated facilities (e.g. hospitals, stand-alone labs, pharmacy chains) emulate modern HRH practices. However, the majority of PHPs are single-owner facilities too small to have HRH management systems in place.

9.2.2 Challenges confronting the HRH sector

Uganda, like many developing countries, faces formidable challenges in HRH:

- Critical health workforce shortage. In 2006, the WHO Report on HRH listed Uganda as one of 57 countries worldwide (36 are in Africa) experiencing a critical shortage of health workers. Uganda's has only one doctor, nurse or midwife for every 714 persons (CAPACITY Project, 2014) and this is below the WHO recommended level of 2.3 health workers per 1,000 persons. In addition, only 60% of public-sector positions are currently filled (CAPACITY Project, 2014).
- Overall satisfaction among Ugandan health workers is low. According to a MoH 2007 study, fewer than half the respondents were satisfied with their jobs. Low salary, poor working conditions and unmanageable workloads were the reasons most frequently cited for low HRH morale. Additionally, performance problems, low retention, lack of skills, poor motivation, and absenteeism abound within the health workforce (CAPACITY Project, 2014).
- Retention is a problem. The 2007 study found one in four health workers interviewed would leave their job immediately if an alternative was available. This number is even higher for physicians – one out of two. Although most HRH move between public and private sectors, some turnover involves outward migration as well as several individuals leaving the health profession completely.
- Inaccurate or incomplete data about the health workforce persists. As the PSA experience revealed, there is scarce and fragmented data on HRH in the PHP sector. This problem is further compounded by the fact that many qualified HRH are not registered with their respective regulatory bodies. Poor data hampers workforce planning and decision-making.
- HRH production remains a challenge. The education system is not producing a sufficient number of HRH nor is it producing the type of health workers needed, with acute shortages in critical fields such as midwives, anesthesiologists and pharmacists.

“UPMB faces high staff turnover because of the inability to pay competitive salaries. Most are moving to government.” Senior Manager, UPMB

9.2.3 Political Commitment to Address HRH Challenges

There is growing recognition and political commitment to address the HRH shortage in Uganda. In the last three years, there has been ongoing and high-level efforts to champion HRH issues in response to staffing shortages, salary deficiencies and greater quality control (Oketcho, 2015).

⁶⁹ The CAPACITY Project also supports the medical bureaus to put into place HRH management systems and to use the same planning tool

The HRH TWG in the MoH, which is comprised of a wide range of key stakeholders – various ministries, professional councils and PNFP organizations as well development partners - has taken a proactive role in fostering this political commitment and funding support.

Upon reviewing government policies and funding levels, the HRH TWG developed an agenda for reform comprised of “priorities of priorities” to be address in the HRH sector (See Figure 9.1). These priorities are aligned to the Global Forum HRH Commitment Strategy, which focuses on these four key areas with specifies strategies in each of focus areas, and lists indicators to measure success:

- Increase availability of health workers;
- Attract and retain health workers;
- Increase health work productivity and accountability; and
- Strengthen public-private partnerships.

These HRH commitments were integrated into the HSSIP 2015-2019, while the coordinated efforts by all stakeholders from the HRH TWG have positively influenced government commitment and funding towards HRH challenges in Uganda. The MoH received a 6% increase in 2014-2015 in its overall budget, of which some of the extra funds were allocated to strategies to attract and retain rural health workers (Oketcho, 2015). It is interesting to note however, that despite the TWG’s inclusiveness, the PHP sector is not consistent in attendance.

9.3. Production

Uganda is known for pioneering health worker training for countries in ECSA. At the time of independence in 1962, Uganda had established an enviable health care system and reputable health raining institutes (HTIs). However, Uganda’s health care and education system suffered a major setback in the 1970s and 1980s arising from political instability and civil strife. The two decades of political unrest and accompanying economic downturn left the country devoid of health services and the pride of the health worker was reduced to despair. The post war recovery program was not helped by the HIV/AIDS epidemic that took advantage of the weakened health system to ravage the population including health workers.

Since then Uganda has made great strides in building its training capacity (see Table 9.1). Rapid growth in the last five years of the private sector institutions and increased support by government and development partners to PNFP and government nursing and midwifery HTIs has resulted in a steady increase in production of key health cadres such as general nurses and midwives. The PNFPs have de facto become the places for “industrial training” or “internships” for a good induction of new graduates destined to work in government and other organizations. The PNFP nurse and midwifery HTIs have been successful in adopting a range of innovative training approaches such as: extension programs for health workers in the service, e-learning platforms, and distance learning programs that require limited expansion of physical infrastructure and staffing to increase training outputs (MESTS, 2015).

Figure 1: Uganda Global Forum Commitments: Results Framework

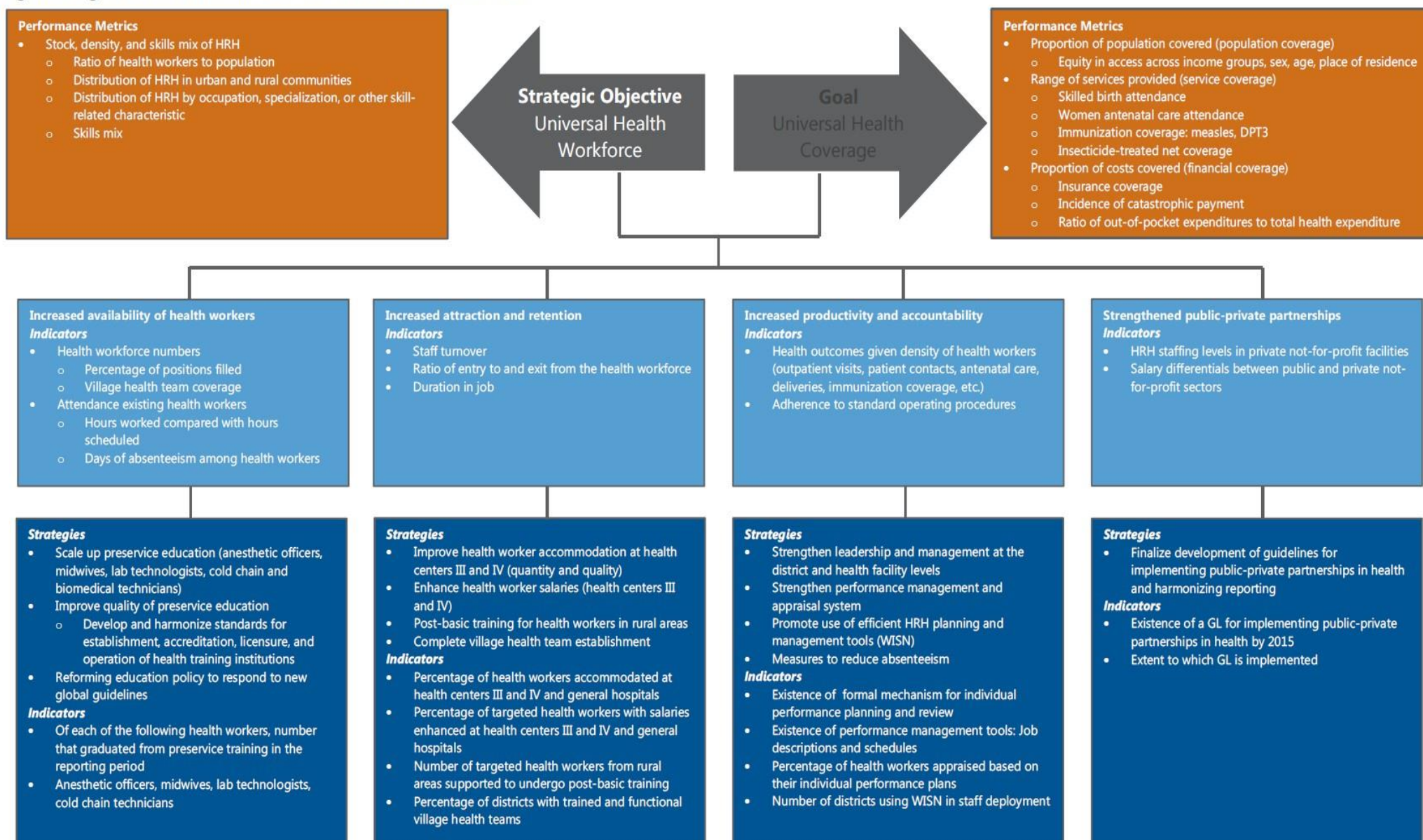


Table 9.1: Summary Annual Outputs of Nurses and Midwives from 2010 to 2014

Level	Training Program	Year					Total
		2010	2011	2012	2013	2014	
Diploma	Comprehensive Nursing	246	314	277	229	268	1,334
	Nursing	356	349	302	401	467	1,875
	Midwifery	271	239	254	268	429	1,461
	Mental Health Nursing	46	40	39	45	56	226
	Pediatric Nursing	0	0	0	2	0	2
	Public Health Nursing	0	0	0	2	0	2
	SUBTOTAL	919	942	872	947	1,220	4,900
Certificate	Comprehensive Nursing	1,534	2,966	1,072	2,256	2,315	10,143
	Nursing	83	271	393	763	1,618	3,128
	Midwifery	140	228	229	546	1,214	2,357
	SUBTOTAL	1,757	3,465	1,694	3,565	5,147	15,628
TOTAL		2,676	4,407	2,566	4,512	6,367	20,528

Source: Inventory of Health Training Institutions 2015, MoES/CAPACITY Project

As Table 9.1 notes, the PNFP and PFPs increasingly play an important role in training of HRH. According to the MESTS study (2015), of the total 143 HTIs, 48% are owned and operated by PFPs, 24% by PNFP organizations compared to 28% by the public sector. All public HTIs are licensed and registered but there a significant number (52.4%) of PNFPs and PFPs are licensed but not registered. As a result, many of the students who graduate cannot be registered to work in Uganda.

It is important to note that gains made in increasing training capacity come with challenges of ensuring the quality of training. The quality of skills training in pre-service training institutions is affected by an acute shortage of qualified tutors, clinical instructors and mentors (MESTS, 2015). The situation is aggravated by inadequate space and equipment in the skills laboratories. A few PHP HTIs have made significant investments in infrastructure development and purchase of learning and teaching materials and equipment but most are highly challenged to meet the required standards. Development partners play a major role in addressing these gaps by donating learning, teaching materials and equipment, providing scholarships for students from poor families, and offering professional development for teaching staff in midwifery and medical laboratory technology programs. However, this support is only directed to public and PNFP HTIs.

Table 9.2: Summary of HTIs by Ownership and Registration Status

TYPE of HTI	Status	Public	PNFP	PFP	Total
Nursing/Midwifery	Registered	14	7	6	27
	Licensed	0	19	30	49
	Not registered, not licensed	0	0	3	3
	Subtotal	14	26	39	79
Allied Health Professions	Registered	22	2	6	30
	Licensed	0	7	19	26
	Not registered, not licensed	0	0	3	3
	Subtotal	22	9	28	59
University Medical Schools	Registered/ Licensed	4	0	1	5
TOTAL		40	35	68	143

Source: Health Training Inventory, MoES/CAPACITY Project

The quality of medical education is also affected by over-enrolment of trainees beyond the design capacity of the institutions. The MESTS assessment in 2015 found that the number of students enrolled in most public and PHP HTIs for clinical officers, medical laboratory personnel, nurses and midwives was more than the design capacity and tutor establishment. Further, PNFPs HTIs were more likely to keep within range of their approved design capacity for the institution in urban areas. Rural areas had slightly higher enrolment numbers.

Despite these challenges, Uganda appears to be on the path to meeting its commitment to increase the number of qualified HRH.

- University medical schools (3 public and 1 private) are experiencing an increase in enrollment and graduation of doctors in both graduate and post-graduate programs. On average, 250 medical doctors graduate every year.
- Graduation rates in all the nursing and midwifery programs have increased steadily in the past five years. The production of general nurses and midwives in the certificate programs is projected to increase by two folds in the next 3 - 4 years when trainees currently enrolled in the HTIs start to graduate.
- Some allied health professions – medical laboratory personnel, clinical officers and environmental health officers – have increased their number of graduates in the last five years. There are however, several key health cadres among allied health professions that are struggling to attract students. As a result, they experience negative growth patterns. These include anesthesia, occupational therapy, psychiatric medical clinical officers and pharmacy technicians.

9.4. Recruitment

Uganda set a goal in the 2010-2015 HSSIP to have 75% of approved health worker positions for the public sector filled by June 2015. Although there have been improvements, MoH statistics show that as of July 2015, 69% of the approved positions for public sector health workers were filled, (CAPACITY Project, 2014).

Data for PHPs is not readily available, but Table 9.3 offers a snap shot of the labor shortages by cadre in the public and PNFP sectors. In the last five years, the government has made a deliberate effort to fill the numerous vacancies. There are critical shortages in health professions such as anesthesia (67%), pharmacists (54%), allied staff (48%) and physicians (47%). Of all cadres listed, only a few professionals - clinical officers and laboratory staff - are filled to acceptable levels: 83% and 84% respectively.

Table 9.3: Staffing norms for select cadres (Public and PNFP subsector)

Cadre	Norm/Manning	Filled/Available	Gap	Filled (%)
Doctors	2,677	1,408	1,269	53%
Nurses	27,053	20,635	6,418	76%
Midwives	13,506	9,802	3,704	73%
Clinical Officers	3,919	3,260	659	83%
Laboratory staff	3,810	3,193	617	84%
Anesthetic Cadre	1,169	385	784	33%
Pharmacists	150	69	81	46%
Dispensers	608	341	267	56%
Other allied staff	7,103	3,677	3,426	52%
Total	59,995	42,770	17,225	71%

Source: HRH Audit Report, 2015

Secondment of staff is a useful stopgap solution for PNFP recruitment challenges, which has largely been limited to doctors, but for the managers of PNFP facilities, handling staff belonging to a different administration has created challenges. Since 2003, the MoH reserves 118 posts for deployment to the PNFP sub-sector, mostly medical officers (PNFP subsector report, 2007). The MoH secondments represent a very small proportion (about 4%)⁷⁰ of the total PNFP workforce of approximately 10,000. Historically, the MoH has only been able to fill 50% of the “reserved” posts for secondment to PNFP facilities.

In most instances the posted staff, especially the doctors, receive both their government pay and a variable top-up from the PNFP employer. Considering the fact that PNFP (hospitals) are quite often located in rural and unattractive environment, this practice constitutes a “de facto” hardship allowance.⁷¹ It also represents “special treatment” for civil servants, creating salary inequities among physicians because PNFP physicians are generally paid considerably less than their public sector counterparts.

PNFPs have been forced to raise salaries of their PNFP doctors in facilities with MoH secondments to preserve harmony among colleagues working in the same environment but belonging to different administrations. Many of the PHP owner/managers stated that it is difficult to compete with the salary levels offered in the PNFP and public sector.

9.5. Retention

Box 9.1 illustrates the factors that contribute to high turnover rate. These factors hold true no matter the place of employment whether it is a public or private health facility. The following discussion is based on the 2007 MoH study on HRH job satisfaction in Uganda.⁷²

⁷⁰ A remarkable exception is Kilembe Mines Hospital. The hospital is a partnership between the Kilembe Mines Company and Catholic Diocese of Kasese. A very large proportion of staff are civil servants, a situation inherited from the previous arrangement.

⁷¹ Hardship pay for PNFPs has been a historical practice for PNFP to attract doctors to rural hospitals. But the current MoH salary levels has created a wide gap between PNFPs and seconded MoH doctors

⁷² MoH/CAPACITY Project, 2007. Uganda Health Workforce Study: Satisfaction and Intent to Stay Among Current Health Workers; Executive Summary.

Longevity. Interestingly, HRH in Uganda stay a relatively long time – ten years with the same employer and more than 13 years in their profession) years. Health sector jobs are relatively high status positions, stable and reasonably compensated compared to another sector. Despite the longevity in one’s health profession, almost half (46%) would leave their job (20% within three years and 26% as soon as possible). Of those who would leave their current job, they were evenly divided between public and private sectors indicating similar levels of job dissatisfaction.

Job Satisfaction. Of the factors listed in Box 9.2 influencing one to leave his/her job in the Ugandan health sector, job dissatisfaction is the biggest driver. Once again, there is no difference in the motivation to leave a job if one works in the public or private sector. The 2007 study revealed that **overall job satisfaction among Ugandan health workers is very low irrespective of where they work.** Stakeholder interviews confirmed this finding even with PHPs.

The **most cited reason for high job dissatisfaction is low wages.** Not surprisingly, doctors are the least satisfied group when it comes to salaries. Only 11% of respondents believed their salary package are fair. Interviews with PNFP and PFP providers for the PSA revealed that leading reason for leaving their job is low wages. Many PHPs complained they could not compete with public sector salaries and job security. Significant percentages believe their compensation package should include health care for dependents (90%), retirement (87%), housing (83%) and transportation (77%). Very few employers offer such benefits to their staff except for the MoH, but even their benefits are limited.

Working conditions is the second reason for job dissatisfaction. Both the public and PNFP facilities struggle to keep pace with key inputs needed, such as equipment, supplies and drugs, to deliver quality health services. Moreover, many rural facilities lack basic inputs such as electricity and water. Only half (51%) said they had access to supplies needed to perform their job safely and less than half (48%) had access to equipment needed to perform their job well. Lack of basic supplies and facility conditions is less of a problem in the PFP sector (MoH, 2007). Many health professionals find it challenging or even impossible to work under such conditions, contributing to absenteeism; high staff turnover or even under-hand payments for would be free services.

Retention. According to the census carried out by MoH in preparation of HSSP II, the total HR gap in the sector – GOU and PNFP – was 4,909 units (4,582 medical / clinical and 327 others). Of this total, over half of the vacancies were in PNFPs: 54% comprised of 1,974 of medical / clinical staff and 657 others. The gap exists for all considered cadres. Since the census, the total number of staff (both total and per bed) has decreased even further due to high levels of attrition especially of key clinical staff.

GOU has implemented several strategies to recruit and retain staff, which has greatly affected the PNFP sector. In light of budget stagnation, several local governments have “topped-up” salaries to retain current staff increases to cover salaries amounts they receive from the central government.

Box 9.1: Factors Influencing Turnover in HRH

- Dissatisfaction with job
- Deteriorating living and working conditions
- Weak management performance and supervision structure
- Inadequate infrastructure and supplies
- Lack of recognition for good work
- Stress due to heavy workload
- Limited opportunities for career development and advancement
- Safety and security reasons
- Gender-related issues

Box 9.2: Reasons for Job Satisfaction

- Workers’ skills and experience is a good match with the job
- Worker is satisfied with compensation
- Worker is content with supervisor
- The job offers security
- Workload is manageable
- The job is stimulating

Source: MoH, 2007

In addition, payroll management was decentralized to local government in 2014 to ensure more timely payment of salaries. The MoH has provided retention allowances for doctors working in HC IV amounting to 67% of their basic pay. It is interesting to note that the departure of PNFP staff coincided with MoH's efforts to recruit new staff and retain existing ones.

Total attrition rate in the PNFP in 2005/06 was about 16% (see Table 9.4). Of those who left their post in a PNFP facility, at least 40% went to a government job. Another 34% did not state their destinations but it is most likely they also joined government services. In fact, a PNFP study showed that upwards of 60% to 70% left their job to work in government, mainly to vertical programs such as HIV/AIDS programs. When asked why PNFP staff left, almost two-thirds (61%) left because of low wages, 35% stated low pay and another 26% in search of better opportunities (UCMB and UPMB, 2014).

Table 9.4: Attrition Rates per Selected Staff Category in Sample of 65% PNFP Hospitals (N=29)

Cadre	2003/04	2004/05	2005/06
Medical Officers	28%	21%	30%
Clinical Officers	22%	21%	36%
Enrolled Nurses	16%	17%	26%
Enrolled Midwives	15%	10%	34%
Registered Midwives	9%	11%	27%
Registered Nurses	5%	14%	11%

Source: PNFP sub-sector report, 2007

Although the MoH has not collected data on PHPs recruitment and retentions, the PSA interviews revealed that private facilities also struggle to retain staff. Although working conditions are better in private facilities, low salaries and limited training opportunities in the private sector are the most common reasons cited why PHP staff leave to work in the PNFP and public sectors (Yumkella, 2007).

9.6. Performance and Accountability

The 2007 MoH report cite that two-thirds of the respondents said their workload is unmanageable. The PSA site visits and interviews revealed wide variance in this finding. In general, the government hires greater numbers of health workers for a lighter workload, so public health workers work less than their counterparts in the more streamlined PNFP facilities. Salaries and employment are guaranteed in government facilities even when health workers do not perform. Yet there are key public facilities – such as Mulago, Naguru Hospitals and the RRHs, as well as PNFP ones – like Nsambya and Lacor Hospitals that are highly congested, reinforcing the finding that workload is overwhelming. In comparison, the PHPs owners stated the workload is not only manageable but there is room to attend to increased patient load. They also indicated their interest in partnering with the MoH to help decongest hospital and other services.

In addition to performance, there are several factors related to work place ethics. The MoH 2007 study observed that some health workers in public facilities are illegally charging patient fees. The PSA team also learned of similar practice. The same study noted that some public health officials abuse their position of power by extracting payment to become employed, or are required to pay in order to get their paycheck processed.

Dual practice is widely practiced in the health sector. Many health cadres, ranging from doctors, to clinical officers and pharmacists, work in both the public and private sector. Although legal, there is no clear guidance regulating this practice. As a result, many abuse this benefit. Several interviews cited that many public sector doctors are running their private practice during the time when they are supposed to be on duty in a public facility. Some of these health workers are appropriating drugs and supplies from public facilities for their private practice. The PSA team also observed the reverse in private facilities is possible – where the private pharmacy is owned by a public sector pharmacist but s/he is not at the private pharmacy but instead at his/her post in the public facility. The end result is compromised quality in both public and private facilities. Many stakeholders interviewed identified normalizing dual practice as a high priority.

“There’s need to normalize dual practice/moon lighting as it is a common occurrence. It is time Uganda thought about a policy/strategy to regulate it rather than ignoring it and pretending it is not happening.”

KCCA Health Official

To address problems of absenteeism and low productivity levels, the MoH has developed and rolled out performance management guidelines and processes. The MoH has also piloted an electronic system to document and report on individual work attendance with the goal of reducing absenteeism by 50% by 2019 (IntraHealth, 2015).

9.7. Public-Private Mix of HRH

Total Size of HRH. The 2002 HRH Census indicated there were 59,680⁷³ people with either health occupation, or non-health occupation but working in the health sector (government, PNFP and PHP). The number working in the government and PNFP sub-sector is estimated between 30,000 and 35,000. Table 9.5 below shows the distribution of HRH among the respective sectors.

The PNFP sub-sector employs about one third of the combined GOU and PNFP workforce, i.e. about 10,000 health workers⁷⁴ (PNFP Subsector Report, 2007). The PHP sector is the second largest employer in health, employing a significant number (almost 25,000). However, this number is not reliable due to problems associated with data collection in the private sector. The level of moonlighting further compounds the unreliability of number of PHPs. Although there is no official estimate, it is estimated that three quarters of the PSA respondents work in the public and private sector - in the PHP sector mostly.

Table 9.5: Public-private Mix of HRH distribution among sectors

HRH Category	Total	Public	PNFP	PHP
Doctors	5,141	1,047	361	3,733
Nurses	28,885	16,490	4,145	8,250
Midwives	9,802	8,815	987	**
Clinical Officers	6,685	2,702	558	3,425
Laboratory staff	8,926	2,447	746	5,733
Anesthetic Cadre	385	238	147	
Pharmacists	657	45	24	588
Dispensers	551	169	172	210
Other allied staff	6,205	3,295	382	2,528
Total Available	67,237	35,248	7,522	24,467

Sources: Public sector data adapted from MoH HRH Audit Report 2011, PFP and PNFP data adapted from Professional Councils’ databases, PNFP websites, Uganda Healthcare Directory 2013-2014 and UPMA data

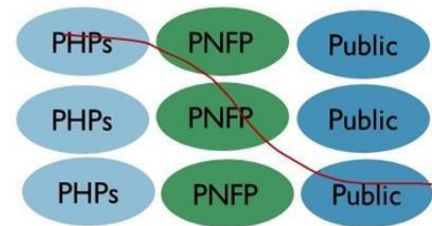
⁷³ MoH; Human Resource for Health Policy April 2006

⁷⁴ MoH. HSSP II. 2010

9.8. Key Findings

- Uganda still suffers from a critical shortage in HRH. Overall, the total number of HRH – public and private together – is still low compared to international standards. Rapid growth in the last five years of private sector institutions and increased support by government and development partners to PNFP- and government-nursing and midwifery HTIs has resulted in a steady increase in production of key health cadres such as general nurses and midwives. However there are still gaps in essential cadres such as pharmacists and lab technicians.
- Other conditions plague the entire HRH system in Uganda such as low morale among health workers, poor working conditions, and difficulty in recruiting and retaining staff. As the diagram illustrates, those HRH staff, which start in a PHP or PNFP facility, eventually end up in the public sector. PNFP experience high turnover, citing low wages and better opportunities as the reasons for leaving.
- Although working conditions are better in private facilities, low salaries are the most common reason cited for leaving to work in the PNFP or public facility. Once they arrive in the public sector, staff morale is low due to poor working conditions and low productivity due to with high absenteeism. Although these problems are common among public, PNFP and PFP facilities, they affect each sector differently indicating that **one solution will not “fit” all three sectors**.
- Stakeholders interviewed consider **PNFP and PFP HRH management to be more agile and responsive**. Private sector employers are not subject to same policies and systems found in public sector. The bureaus play a critical HRH management role but struggle with many of same HRH challenges as the public sector despite their more agile HRH management systems while the larger PHP apply international HR best practices. Smaller PHPs facilities struggle to put in place in HR management and policies.
- There is strong political commitment among MoH leadership and development partners to address HRH issues to respond to staffing shortages, salary deficiencies and greater quality control HRM. The HRH TWG has taken a leadership role in fostering this political commitment and has brought together a wide range of key stakeholders – various ministries, professional councils and PNFP organizations as well development partners – to advocate (successfully) for more funds. However, **representatives from PFP sector have not been included in HRH policy and planning** despite the fact that they employ 35% of the total HRH workforce.
- There is a lack of work ethics not only in private sector but also in public sector. HRH performance varies across public, PNFP and PFP sectors. Dual practice is widespread and affecting quality of care. It is common for both public and PNFP providers to have a private practice on the side. There is no data documenting magnitude of dual practice and its impact on the sector. However, studies documenting health workers in public facilities have observed appropriating drugs and supplies from public facilities for their private practice, illegally charging patient fees, and some public health officials extracting payment to become employed or to process pay checks (MoH, 2007)
- Indeed, **PHPs remain virtually outside of the HRH system**. To date, all efforts to address the HRH challenge have focused exclusively on the public and PNFPs. In formulating HRH production levels and HRH plans, the MOH only considers HRH needs in public and PNFP sectors. This may stem from the lack of data on PHPs. As noted in earlier sections, basic data on the number of PHP facilities and HRH staff is not collected routinely and consistently. As a result, the MoH does not consider possible linkages and opportunities to tap into the PHP HRH though they employ many of the specialists and lab technicians and almost all of the pharmaceutical staff missing in public and PNFP systems. Although the private sector greatly contributes to solving the HRH challenges in Uganda, there is no data to back up this assertion.

Figure 9.2: HRH Labour Movement



Source: SHOPS Research Insight, 2014

- Despite the fact that PHP contribution to HRH is undercounted, *all three labor markets are interconnected*. As the PSA interviews reveals, there is considerable movement between the three sectors for a variety of reasons. In fact, there is almost an informal ranking between the labor markets:
 - Working conditions are considered better in PNFP and PFP sectors compared to public sector because of greater availability of key inputs needed to perform one job. Further, housing for PNFP staff, unlike that of public employees, is often provided within a community that has its own electricity, running water, and even small markets.
 - Salaries are better in PNFP facilities compared to PFP ones. Moreover, there are more opportunities for professional development while working in a PNFP facility due to development partner and/or government-supported trainings.
 - But there are variations in salaries. Physicians in public facilities are remunerated at lower rates than their counterparts in PNFP facilities, whereas nurses, midwives, and other cadres in government service are generally paid more than those in PNFP and PHP facilities.
 - All those interviewed agreed that salary and job security were better in the public sector. Government facilities are perceived as being more stable and dependable, better known, and more likely to provide training opportunities and secure career paths. In addition, workloads in the public sector are considered more manageable compared to PNFP and PFP jobs.

Take Home Messages on HRH in Uganda

- There is consensus that Uganda health sector still suffers from a HRH shortage. The total number of HRH – public and private together – is still low compared to international standards. With donor support, Ugandan PNFPs health training institutes have rapidly increased and continue to steadily produce key health cadres such as general nurses and midwives. But gaps remain in select health cadres, such as pharmacists, medical laboratory pathologists and anesthesiologists. And distribution of health professions shows that MoH employs most nurses and midwives while the PHPs engages almost all specialists and pharmacists.
- Low morale, poor working conditions, low wages plague HRH across the sectors. All three sectors struggle to recruit and retain staff, and poor staff performance. HRH productivity varies across sectors and within each sector. Some MoH facilities overcrowded and overworked while others have absent workers. Some PHPs have high performing, productive staff while others, usually smaller PHPs, have over capacity, and are waiting for clients. Although these problems are common across sectors but affect each sector differently. One solution will not “fit” all three sectors.
- PHPs remain virtually outside of the HRH system. The MoH does not collect consistent data on PHPs. MoH policy and planning focuses exclusively on public and PNFPs sectors. As a result, PHPs are not included in HRH policy and planning. All donor-funded and MoH reports on HRH in Uganda under estimate and do not account for PHPs contribution in labor.
- All three labor markets are interconnected. There is considerable movement between the three sectors for a variety of reasons with informal ranking between the labor markets: 1st public sector, 2nd PNFP and 3rd PHPs. Working conditions are considered better in PNFP and PFP sectors compared to public sector. Salaries are better in PNFP facilities compared to PFP ones. All those interviewed agreed that salary and job security were better in the public sector.
- There is limited planning of HRH labor markets in Uganda. The MoH mixes its HRH stewardship functions with its HRH management responsibilities. Stewardship functions include HRH planning and production for the entire health sector including PNFP and PHPs staffing needs, while management functions include ensuring peak performance of all HRH labor markets (e.g. distribution, mix, remuneration). These two tasks are confused MoH’s need to manage, like any large business, its own staff throughout working throughout its network of health facilities.
- Given the symbiotic relationship between the labor markets in all three sectors, any reforms in HRH need to consider the downstream impact not only on the public sector’s *but also* on PNFPs’ and PHPs’ ability to recruit and retain staff.

As the stakeholder interviews revealed, recent reforms have negatively affected both PNFPs and PHPs; salary increases in the public sector resulted in health workers flooding the public sector and leaving the PNFPs and PFP understaffed, distorting the placement of health workers across both systems.

9.9. Recommendations

In order to guarantee that every Ugandan has access to a health worker, Uganda must examine the public and private sectors together and consider how to better align and leverage both sectors, acknowledging that changes in one sector will impact the other. Moreover, development partner programs also need to reflect on their support will help facilitate but also possibly distort health worker movement across sectors.

The following are recommendations to help strengthen MoH's capacity to govern the overall HRH system that includes all private sector stakeholders including PHPs, and to build PNFPs and PHPs capacity to manage their respective network of HRH.

1. **Separate MoH functions to steward and plan for all HRH from the need to manage its own HRH.** As this section shows, there are two functions needed but they have become muddled. It is critical the MoH also focus on its stewardship role in managing HRH labor markets as well as manage its own network of HRH staff. The CAPACITY Project has documented the range of interventions needed to strengthen MoH capacity to manage and develop its workforce:

- **Establish a new cadre of HR managers in the MoH.** HRH managers must be specialists not generalists which will require training, technical assistance from other HRH professionals (not necessarily in the health sector) and on-going mentoring in this new role, and new scope enabling them to provide real into operational and strategic decisions related to HR management. This function and professional cadre should reside at both the central and district levels.
- **Create staff and invest in a HR Unit or Directorate.** A HR Unit or Directorate will convey the importance of this new management function within the MoH, raise their profile and visibility within the MoH hierarchy, and strategically place this function within the MoH leadership and management structure. A new Directorate will also ensure a reasonable budget and staffing to fulfill its dual role and functions as steward of the HRH labor markets and HRH manager of MoH staff.
- **Develop and deploy HR managers.** Traditionally, the MoH has promoted physicians to manage its facilities and staff. In a decentralized health system like Uganda's, it is important to identify and invest in HRH managers for high-volume hospitals and larger clinics. This may require hiring new HR professional and hospital managers, but in most cases, it may involve recalibrating the role of existing staff and providing additional HR management training and adapting their scope to assume a full-time HR manager.
- **Build on and continue to refine the HRIS system.** The CAPACITY Project has played an instrumental role in assisting the MoH to establish a HRIS system to track public HRH. As the PSA revealed, the government is actively using this tool to manage and plan for its own MOHs staff working throughout its vast network of facilities. But problems and "bugs" still exist. It is important to continue supporting the MoH to consolidate its advances and to improve the HRIS application as a management tool for MoH staff. Moreover, the HRIS can become a tool to plan and manage the overall HRH labor markets between the three key sectors – public, PNFP and PFP. However, there are some serious data issues both for PNFPs and PFPs (see below).

- **Strengthen MoH recruitment and deployment practices.** CAPACITY Project’s research shows it takes, on average 12-18 months for SSA to recruit and deploy health workers when funds are and workers are available in the local labor market (source). Strengthening government’s capacity and systems. The quickest path to improve government systems may involve identifying and applying private sector practices. CAPACITY Project cites two country examples – Namibia and Kenya – where they applied and/or contracted out HRH management to private sector firms to speed up recruitment and deployment (source).
 - **Revamp supervision and performance support.** The available evidence suggests that the traditional model of a visiting supervisor has not worked well, is costly to implement and has not improved performance of the public or private health staff (Benavides, 2009). Experience from the private sector in health and in other economic sectors demonstrates that a site-based approach to workforce performance - in which team works collaboratively with their site supervisors and uses simple QI tools such as the recently launched SQIS – to set priorities, remove obstacles, resolve challenges and enhance competencies.
2. **Strengthen MoH capacity to steward and plan for all HRH needs across the sectors** (Martineau, Tim, 2008). Part and partial to strengthening the MOH’s stewardship role of all HRH in a mixed health system, it is imperative for development partners to invest in the MOH capacity to plan and manage HRH labor markets. This entails: i) developing and implementing long-term HRH strategic plan that will form the basis for a sector-level action plan, ii) enhancing the HRIS system to include accurate and reliable PNFP and PHPs data as a HRH sector wide planning tool, iii) consolidating and centralizing all MoH agency’s data (e.g. Councils, MoH service statistics) to create an accurate data base on all HRH, iv) conducting periodic labor market analyses between the public, PNFP and PHPs to understand and manage labor movement and compensation, and v) regularly consulting and involving private sector employers and their professional associations in HRH policy design and implementation as well as HRH labor planning (see below).
 3. **Strengthening Professional Associations to represent all HRH in policy planning.** Understandably, capacity building of professional associations is a neglected area by development partner because of all the challenges. Professional Associations requires a large investment of time and resources, limited staffing and leadership to drive Association and high financial uncertainty because of small membership numbers and low membership dues.

However, the benefits of building professional associations’ capacity are evident in the long run (McQuide, P. 2007). Professional Associations are an important bridge between health consumers, healthcare profession and the government. A strong professional association ensures the public of high standards of care while motivating health professionals to improve quality of care continually.

Although there is no formula for strengthening professional associations, experience shows that successful strategies fall into two board categories: 1) strengthen a professional associations internal structure and organizational effectiveness, and 2) strengthen a professional association’s capacity to carry out key member activities, such as legislative affairs, continuing medical education and accreditation to name a few. Most successful example focus on both strategies simultaneously (McQuide, P. 2007).

10. RECOMMENDATIONS TO HARNESS THE UGANDA PRIVATE HEALTH SECTOR

The PSA Team made multiple recommendations in each section that would help the MoH harness the private sector to improve access to basic health services and essential medicines as well as strengthen critical health system constraints to the private sector. The recommendations are comprehensive and ambitious. To help the Ugandan public and private stakeholders in health think through and prioritize the long list of possible interventions, the PSA Team proposes a strategy that prioritizes the wide array of recommendations and suggests timing to implement them – Implementation Road Map.

As the PSA Report notes, both the public and private sector lack many of the tools and operating systems needed to effectively interact and collaborate with each other. As Ugandan government officials and private health sector leaders embark on this journey of public-private cooperation and partnerships, the proposed Strategy focuses on laying the foundation and building the institutions in both the public and private sectors so they can fulfill their respective roles in a mixed health delivery system. As a result, this Strategy emphasizes building the institutional arrangements and capacity needed while at the same time creating opportunities for greater dialogue, collaboration and partnerships. As both the public and private sector stakeholder groups become more comfortable with public-private dialogue, collaboration and partnerships, the Strategy concentrates on a range of PPP/H and less on systems development.

10.1. Roles and Responsibilities

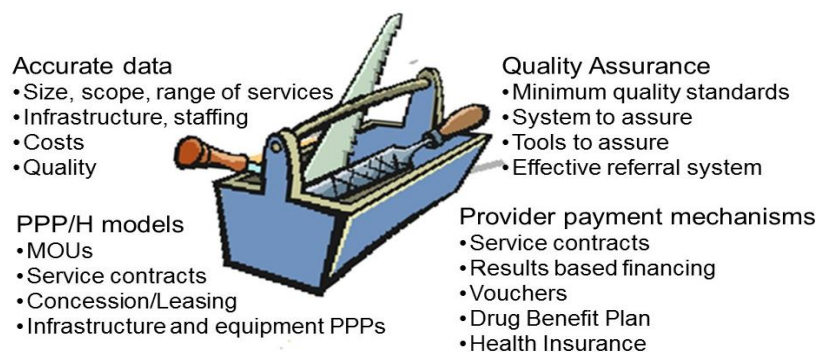
Public Sector Roles and Responsibilities. There are different but complementary foundational building blocks required for the public and private sectors. In the case of the public sector, the GoU and MoH need to: i) have command of specific tools of governance (Salamon, 2009) related to private sector engagement, ii) establish necessary institutions with functioning operating systems, and iii) fully operationalize departments with staff who are trained and have expertise in the new skill areas required to effectively partner with the private health sector (health finance, contract design and negotiation, dialogue and partnership skills, project management, and monitoring and evaluation).

At a minimum, the MoH policy tool kit is comprised of:

- **Accurate and timely data** not only MoH activities but also those of all non-state entities operating in the health system.
- **Streamlined systems and tools** that reduce burden on PHPs while at the same improve quality and assure patient safety in both public and private health services.

Key systems common to both public and private sectors include minimum quality standards, professional certification, facility licensing, continuing education, and effective referral system between sectors.

Figure 10.1 Tools of Governance to Engage the Private Sector



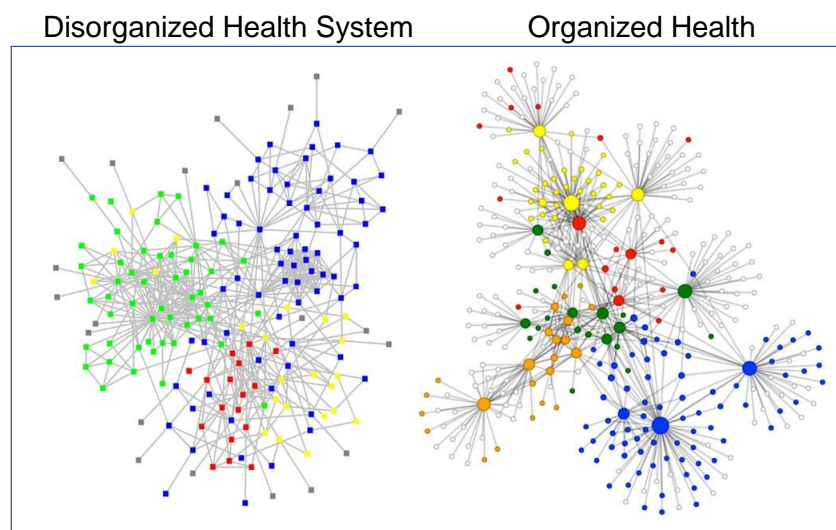
- **Provider payment mechanisms** that can determine true costs, establish realistic reimbursement levels, and ensure timely payments to create incentives for private providers to collaborate and participate in PPP/Hs and to comply with quality standards. Current financial mechanisms contemplated in the Health Finance Strategy include: service contracts, results based financing, vouchers, and health insurance. In the absence of a National Health Insurance program, a Drug Benefit Plan is a new proposal.
- **PPP/H** models that are flexible, adapted to the Uganda health system, and address the health priorities and system gaps. They include MOUs, service contracts, concession and/or leasing agreements and infrastructure and equipment PPPs.

As the MoH gains experience, it can add additional policy tools, co-regulate the private sector through 3rd party entities, and implement more complex partnership models.

Private Health Sector. As a sector, it needs to create structure and organize themselves into entities that can advocate for their interests with the MoH and to facilitate participation in PPP/H projects. Historically, PNFP have been well organized and represented through their individual bureaus. Recognizing the need to form coalitions of mutual interest, PNFPs are in the process of organizing all four Bureaus into an umbrella organization to unify the FBO voice. In addition, UHF has made great strides in the last three years to organize the PHP sector as an umbrella association and has effectively represents private sector perspective in policy and advocacy with the GoU and MoH. More needs to be done to organize the different segments in the private health sector.

Despite the growing organization of private sector voice into umbrella associations whether it be PNFP or PHP, service providers need to organize into some type of structure. Currently the Uganda private health sector is atomized into hundreds upon hundreds of individual providers and facilities operating independently of each other in most cases, outside of MoH governance (as illustrated in Figure 2.2). To date, there are few service provider networks. The individual Medical Bureaus are the largest

Figure 10.2 Disorganized Vs. Organized Private Health Sector



service provider networks in Uganda and as the PSA notes, they collectively manage a range of health infrastructure and health staff. However, there are few PFP service provider networks, particularly of scale.

These service provider networks are a new phenomenon in Uganda. Often referred to as Network Management Organization (NMO), to organize PHPs into NMO will require new systems and management staff who are trained and have expertise in the new skill areas. Vital network management functions include:

- Ensuring all member providers **meet the MoH's minimum quality** standards and as they become partners in a PPP/H project, meet eligibility requirements. The NMO also monitors, in partnership with the MoH, its member quality of care and provider continuous education and training.
- Assisting its members to **operate as a financially sustainable health business** by provide business skills and training, advisory services and facilitating access to credit. Also, the NMO needs to operate as a business and generate revenues to cover its costs as the NMO.

- Assuring **government compliance** with all MoH regulations and reporting.
- Managing **government contracts** on behalf of its members including proposal writing, contract negotiation, contract and financial management, and dispute resolution.

With time, the private sector will gain efficiencies, save costs and go to scale as both PNFP and PHP service providers coalesce and form these NMOs. Moreover, a growing number of NMOs will facilitate partnership with the MoH.

10.2. Strategic Directions and Activities

Figure 10.3 presents a strategic framework to implement priority recommendations. The 5-pronged framework is ambitious and will require that all the stakeholders – public and private alike – as well as Development Partners come together to deliberate and further prioritize the activities outlined in each strategy. Following is a description of each strategy and its core activities, many of which help establish the public and private institutions and build their capacity.

Figure 10.3 Private Sector Strategy

Strategy #1	Build government capacity to assure quality in a mixed health delivery system	<ul style="list-style-type: none"> • Collect standard data on private sector to inform policy dialogue and regulatory reform • Streamline and institutionalize a QA System governing quality in the private sector • Modernize tools (facility registration, professional licensing and CPD credit systems) assuring minimum quality in private sector • Strengthen MoH capacity to steward and plan HRH across all sectors • Move towards “co-regulation” of quality for private sector facilities through a 3rd party
Strategy #2	Create financial incentives to harness the private sector	<ul style="list-style-type: none"> • Encourage the MoH to implement the HFS Strategy • Assist the PPP/H Node to implement financial tools needed to incentivize the private sector to participate in PPP/Hs • Use financial mechanisms to structure the market
Strategy #3	Reduce economic barriers to health services and medicines	<ul style="list-style-type: none"> • Start <i>now</i> to grow MoH’s experience in RBF including PHPs • Scale the MH voucher program nationwide and to include CH • Create a drug benefit plan for priority illnesses among the poor
Strategy #4	Build public and private sector capacity to foster PPD	<ul style="list-style-type: none"> • Foster greater understanding and awareness on the private sector and PPP/Hs • Strengthen public and private dialogue (PPD) • Strengthen public-private coordination and collaboration • Invest in the PPP/H Node’s capacity and systems to partner with the private sector • Invest in structure private sector provider networks
Strategy #5	Broker targeted partnerships to increase access to health services and strengthen health systems	<ul style="list-style-type: none"> • Increase private sector role in delivery of HIV/AIDS and MCH services and products • Increase private manufacturing of basic medicines and supplies • Increase private role in medical equipment (e.g. lab, diagnostics, oxygen, and emergency transport) • Increase private role in medical infrastructure projects (operating theatres and neo-natal units)

Strategy

Strategy #1: Build MoH capacity to assure quality in a mixed health delivery system

The first strategy focuses on building the MoH’s policy toolkit which entails: i) improving data collected so the MoH can better monitor and regulate the private health sector as well as understand the synergies between the two sectors; ii) standardizing tools to monitor quality across both the public and private sector and modernizing key systems to facilitate private sector compliance; iii) strengthening MoH labor planning across all sectors in the health systems; and iv) establishing a regulatory framework and system by which the MoH, over time, can co-regulate with NMOs the quality in the private sector thereby extending MoH’s reach and enforcement to more private providers and health facilities.

Collect Standardized Data on the Private Sector to Inform Dialogue and Regulatory Reform

- Collect more comprehensive data on private sector activities in health
 - MoH reviews all current data collection efforts, analyses accuracy of data collected and designs a strategy to harmonize and streamline data collection into a central location
 - MoH agrees on data needed to regulate and monitor private sector activities
 - MoH discusses with private sector data needs
- Strengthen private sector reporting to MoH
 - PPP/H Node convenes private sector representative organizations to discuss and agree on minimum set of reporting requirement
 - PPP/H Node aids private sector to facilitate reporting
 - MoH collects, analyses and share data regularly with private sector
- MoH uses data to understand private sector trends and issues, to inform dialogue with private sector and to provide evidence for regulatory reforms
- Link SQIS data outputs to DHIS2

Streamline and Institutionalize QA System Governing the Private Sector

- Build capacity and institutionalize the Self-Regulatory Quality Improvement System (SQIS) in all four Councils and DHMTs as mechanism to assess quality in private facilities
- Build capacity among private sector representative organizations - UPMB, UCMB, UMMB, UHF, and UHMG – to apply SQIS among its member facilities
- Centralize data on SQIS, use data to inform policy and PPP/Hs, and share data with private sector entities as sector wide tool describing quality of private facilities

Modernize Facility Registration, Professional Licensing and CPD Credit Systems

- Introduce and roll out web-based system for professional licensure, facility registration, coordinated facility inspections and tracking CPD hours
- Build Councils' capacity to use the web-based platform to i) analyze PHP activities, ii) monitor quality (in terms of updating professional licensure, facility registration and facility inspection), and iii) triangulate with SQIS to develop a comprehensive picture of PHP quality.
- Assist Councils to draft and disseminate quarterly reports on “state of quality in private health sector” and to use in policy dialogue and regulatory reforms

Improve HRH Planning and Coordination across Sectors

- Separate MoH HRH stewardship from internal HRH management functions
- Establish a new cadre of HRH advisors with specialized HRH policy and planning to steward HRH across all sectors
- Build on achievements of the HRIS and further improve data collection on private sector HRH to provide critical information required for HRH planning across sector
- Strengthen and harmonize the professional associations to better fulfill their mandates

Move towards “Co-Regulation” of Quality of Non-State Actors through 3rd Party Entities

- Assist MoH to work with private sector representative organizations (e.g. UHF, Medical Bureaus, Facility Networks) to develop a simple accreditation system based on the SQIS. Steps include:
 - Harmonizing SQIS with the PNFP's quality system
 - Rolling-out accreditation system among 3rd party entities
 - Analyzing SQIS data and generating quarterly reports to be shared with 3rd party constituents
 - Cross-checking with Council data and 3rd party
 - Conducting joint supervision visits to private facilities
 - Conveying regulatory authority to 3rd party after systems have been institutionalized and institutionalized arrangements between MoH and 3rd party entities are normalized

Strategy #2: Create incentives to harness the private sector

The second strategy is based on many elements of the HFS Strategy but with a focus on how to use these financial mechanisms to create financial incentives to harness the private sector.

These incentives can potentially encourage private providers to engage in new activities that can help the MoH address a health challenge and/or system gap (e.g. carry out new health services or produce new products that they may not currently perform; to ensure private providers and facilities comply with MoH quality standards or they will not be reimbursed for services rendered or products delivered; and help organize the private sector into NMOs and trade associations as well foster competition to ensure the MoH receives value for money. The main thrust of Strategy 2 is to establish the institutional arrangements within the MoH and strengthen MoH staff capacity to administer these tools across the public and private sectors. In some instances, such as vouchers and RBF, the Ugandan MoH is not starting from scratch.

Strategy #3: Reduce economic barriers to healthcare and medicines

Using the financial tools of governance established under Strategy Two, the third strategy focuses on designing programs that will reduce economic barriers for targeted population groups to remove access to essential health services and medicines.

As noted above, there are several important initiatives underway to remove economic barriers – vouchers, RBF. The challenge is to grow and scale these efforts. Moreover, in the case of Vouchers, to expand beneficiary

STRATEGY #2: CREATE FINANCIAL INCENTIVES TO HARNESS THE PRIVATE SECTOR

Pressure the Ugandan Government to Approve the NHIS

- Promote understanding of the benefits of a NHIS
- Bring together private health insurance companies and other supporters to advocate for NHIS and pressure the GoU to approve the NHIS
- As a 1st step towards NHIS, aggregate community health insurance and health savings plans

Encourage MoH to Implement the HFS Strategy

- Build understanding of the linkages between HFS Strategy financial mechanisms and PPP/Hs
- Mobilize private sector support through professional associations to encourage the MoH accelerate implementation of HFS Strategy

Assist PPP/H Node to Implement Financial Tools supporting PPP/Hs

- Create and design operating systems for relevant financial tools (e.g. contracting, RBF, vouchers, leasing, etc.)
- Build PPP/H Node's capacity to apply these financial tools
- Use the financial tools to shape key markets (e.g. maternal health, child health) and to organize private providers into management networks

Segment Those Who Can Afford to Pay and Steer Them to the Private Sector

Use Financial Mechanisms to Structure Key Health Markets

- Compel private facilities to join a network as a condition to be voucher or DBP provider
- Empower networks to co-regulate with MoH quality of private providers' MCH services)
- Empower associations and bureaus to become formal network administrators to facilitate development of sustainable private sector healthcare businesses and chains
- Restructure referral system with private and public sectors and align with financing mechanisms

group to include urban poor women while in the example of RBF, to include PHPs as eligible providers. Strategy 3 proposes a new and innovative financing mechanism – Drug Benefit Plan – to pay for essential medicines for the poor only. While the GoU decides to proceed with its NHIS proposal these financial tools – service contracts, vouchers, drug benefit plan (DBP) and RBF – will be the backbone for all PPP/Hs.

Start Now to Grow MoH's Experience in RBF while Putting Systems in Place

- Assist private provider associations to advocate for inclusion in the RBF project design
- Pressure the MoH to rapidly conclude and finalize the RBF proposal in the short-term
- Add PHPs providers to current RBF pilot projects (e.g. Jinja)
- Assist PPP/H to create institutional arrangements for contracting under RBG
- Provide training to PPP/H Node and potential private provider networks in contracting skills

Scale the MH Voucher Program Nationwide and Include CH

- Harmonize the two rural MH voucher programs
- Structure a MH voucher program for the poor to match urban setting
- Identify Ugandan private institutions to become Voucher Management Agency and/or 3rd party, autonomous entity to verify quality and claims payments
- Scale MH nationwide and expand coverage to include child health

Create a DBP to Cover Essential Medicines for Priority Illnesses for the Poor

- Enforce recommended prices for essential medicine
- Design a Drug Benefit Plan (DBP) targeting the poor
- Form a network of eligible pharmacy and drug shop providers
- Roll out the DPB and Pharmacy Network

Strategy #4: Build public and private capacity to dialogue, collaborate and partner

The PSA findings underscore the critical need to foster opportunities for both the public and private sector stakeholders to come together frequently and consistently to dialogue, collaborate and partner with each other. Strategy 4 focuses in strengthening existing policy forums, such as HPAC and PPP TWG, to build trust through dialogue and inclusive policy design and implementation. Each MoH forum requires specific skills to fulfill their respective mandates, ranging from the central role of HPAC as the policy dialogue platform, the PPP-TWG as the coordination body at the central level, and DHMTs and PPP/H Committees at the decentralized level. Strategy 4 also recommends building private sector representative bodies' - UHF and other PHP associations and the ICRU with their member Bureaus – staff and skills so they to become effective policy advocates and policy agents in these different policy forums. Finally, the GoU needs to invest in staffing and training the PPP/H node to build and institutionalize PPP/H capacity.

Foster Greater Understanding and Awareness on the Private Sector and PPP/Hs

- Gather and present evidence on private sector contribution starting with the PSA
- Gather and present international experience in PPP/Hs
- Organize domestic and international tours to observe successful PPP/Hs
- Facilitate greater interaction and dialogue on PPP/Hs

Strengthen Public and Private Dialogue (PPD)

- Embed PPP/Hs in HPAC and strengthen HPAC as sector-wide coordinating body
 - Update HPAC's mandate to become the forum for all public private dialogue including PPP/Hs
 - Establish HPAC's terms of reference to formally integrate all key stakeholder groups, including PHPs, and open HPAC's membership
 - Agree of "rules of engagement"
 - Support the PPP/H-TWG to serve as HPAC's secretariat and build its skill to facilitate dialogue
- Build Professional Associations' to represent their constituents in policy dialogue
 - Strengthen internal structure and organizational effectiveness
 - Strengthen capacity to carry out key member services such as policy analysis and advocacy

Strengthen Public-Private Coordination and Collaboration

- Strengthen PPP-TWG as MoH body to foster coordination and collaboration at national level
 - Update PPP-TWGs mandate to coordination body for public and private sectors
 - Review and update PPP-TWG's composition to ensure balanced representation
 - Agree of "rules of engagement"
 - Support PPP/H staff to regularly convene PPP/H-TWG and to build its skill to facilitate coordination
- Establish PPP/H Committees initially in a select number of Districts
 - Develop guidelines governing PPP/H Coordinating Committees
 - Assign PPP/H Focal Persons in select Districts
 - Form PPP/H Coordinating Committee and meets quarterly and participates in Annual Work plan and Budgeting
 - PPP/H Node provide TA, as needed, to build skills

Invest in Building PPP/H Node's Capacity to Partner with the Private Sector

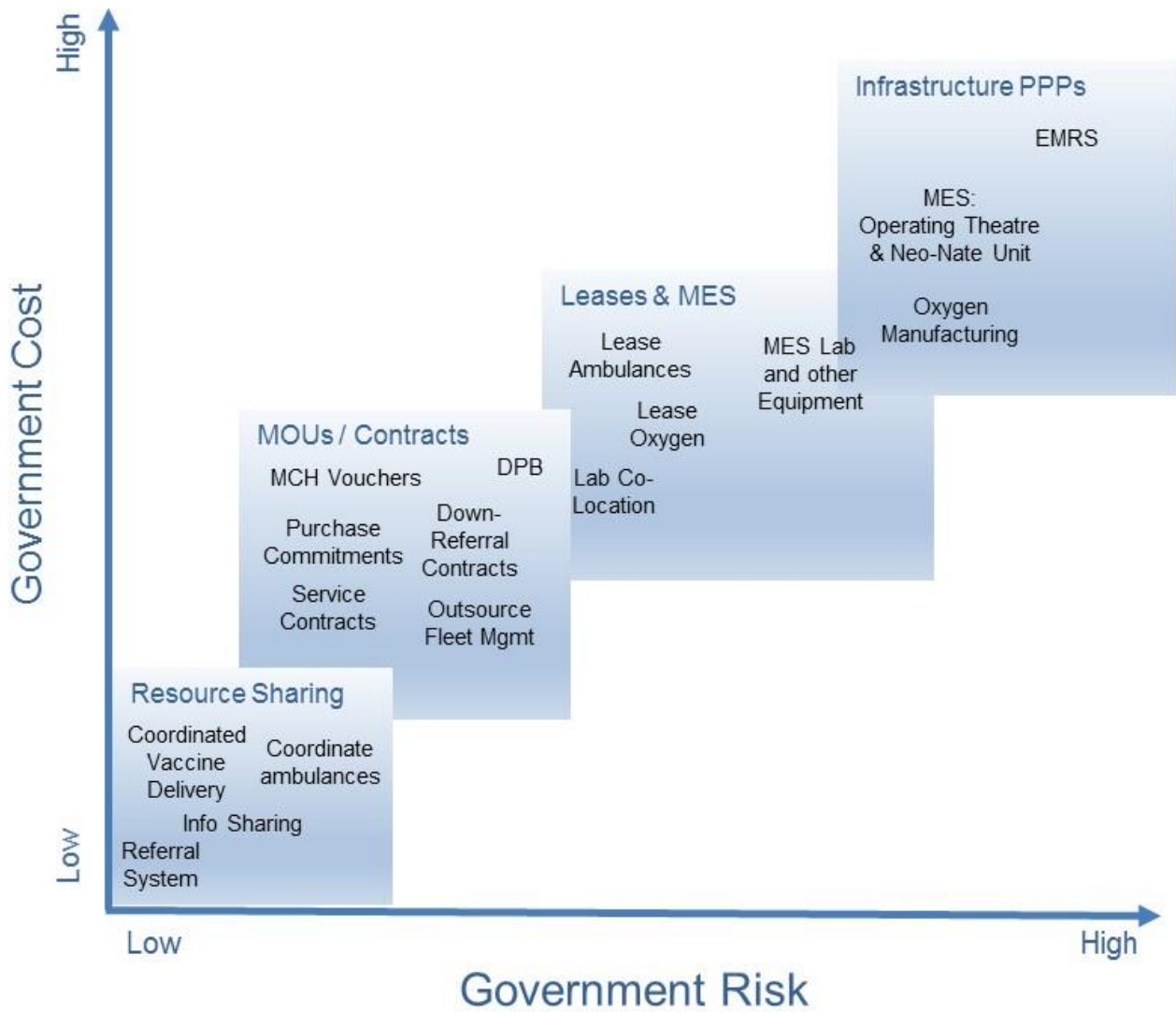
- Allocate sufficient resources to institutionalize PPP/H Node
 - Fully staff Node, draft PPP/H implementation guidelines and establish operating systems
 - Build PPP/H and MoH staff knowledge on private sector and capacity in brokering PPP/Hs
 - Assist PPP/H Node to generate information needed to monitor private sector
 - Support Node to regularly share information on private sector and PPP/Hs
 - Provide TA, as needed, to build PPP/H Node's capacity to coordinate private sector resources and to broker PPP/Hs

Strategy #5: Broker PPP/Hs to increase their role in MCH and community health

Strategy #5 encourages the MoH to operationalize its PPP/H Policy and implement its forthcoming Five Year PPP/H. The Advisory Committee formed to guide the Five Year PPP/H Strategy over 50 potential PPP/H projects. The PSA Team recommends only those that emerged from the PSA analysis. Moving forward, the challenge will be to identify a manageable number of PPP/H projects that the MoH can implement while putting into place the systems and staff needed to manage its growing portfolio of PPP/Hs.

Figure 10.4 ranks a select number of proposed PPP/H projects. The projects identified as low cost and low risk to the MoH are strong candidates for immediate implementation within the next 6 to 12 months. Moreover, the MoH already has 2 voucher projects that the PPP/H Node could build and expand on to include urban poor and children during this time.

Figure 10.4 PPP/H Projects Ranked Cost and Risk



DPB covers wide range of tests and drugs for CH, MH, FP, HIV/AIDs, OIs and TB

Purchase Commitments to encourage local manufacturing of ORS/ZINC, Fortified Food,

Service Contracts for PMTCT, FP outreach, Specialists and Routine Surgery

Increase Private Sector Role in Delivery of HIV/AIDS Services

- Conduct regulate NASA to generate up-to-date data to inform planning, coordination and partnerships
- Allow private providers to access existing continuous professional development opportunities
- Set fees for service for HIV/AIDS services delivered in the private sector
- Segment those able to pay for services and steer them towards the private sector
- Contract private midwives to expand and integrate PMTCT into their current services
- Formalize and strengthen the referral system through down referral contracts

Increase Access to MCH Services through PPP/Hs

- Create incentives to organize PHPs and pharmacies/drug stores into NMOs (see Strategy #3)
- Contract with NMOs to provide specific services under voucher programs (see Strategy #3)
- Contract Pharmacy/Drug Store NMOs to deliver FP methods and RH supplies (see Strategy #3)
- Establish mobile FP services to increase the use of FP methods
- Recruit, bond and train midwives from under-served areas to provide services in their communities
- Increase private role in medical equipment such as lab, diagnostics, oxygen, and emergency transport
- Increase private role in health infrastructure projects through MES (operating theatre, neo-natal units)

Improve Quality and Affordability of Medicines Delivered through the Private Sector

- Streamline and modernize the regulatory mechanisms governing EMHS supply
- Assist local Ugandan capacity to manufacture basic medicines and health products
- Identify PPP opportunities with local manufacturers
- Make EMHS more affordable to the general population through a DBP (see Strategy #3)

In addition, the MoH’s growing experience in contracts, particularly with PNFPs to deliver health services and private companies to carry out non-clinical services, can serve as the basis on which the MoH can build. In the next 2 to 3 years, the PPP/H Node will establish standardized contracting systems under the RBF project to implement a wide range of service contracts.

Finally, there is current GoU discussions on MES for medical equipment, which will partner with private companies – mostly international ones – to rehabilitate and equip operating rooms and ICU.

10.3. Phasing Recommendations and Activities – PSA Road Map

The intent of this PSA is to support the GoU and private sector stakeholders to enhance public-private engagement at all levels of the Ugandan health system. The PSA provides a comprehensive “snap-shot” of the private health sector landscape revealing the multiple health services and health system functions in which private health sector actors make significant contributions. Each section of the report provides key findings and recommendations for enhanced private sector engagement, highlighting actionable opportunities for increased public-private collaboration. Many of the recommendations are cross-cutting and will require strategic action and cooperative engagement between the public and private sector stakeholders. As such, the assessment provides a roadmap (see Figure 10.5) for optimizing private sector inputs within the context of the overall mixed health delivery system. The road map is organized by “quick wins” (6 to 12 months), “low hanging fruit” (12 to 24 months) and “long-term gains” requiring investments in system and capacity building that finally bear fruit in four to five years.

Figure 10.5 Private Sector Road map

Quick Wins 6 - 12 months

Strategy #1:

Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
 - Agree on and collect standardize data
 - Strengthen private sector reporting to the MoH
- Streamline and institutionalize SQIS
 - Build MoH capacity to interpret and report on status of quality in private sector
 - Build professional associations and NMOs to apply SQIS with members
- Continue implementation of modernized tools in MoH and private institutions

Strategy #2:

Create financial incentives to attract private sector to partner with MoH

- Advocate with the GoU to approve the NHI Bill
 - Take steps that will create the foundation for a NHI Scheme
 - Segment those who can afford to pay and "steering" them to the private sector
- Advocate for inclusion of PHPs in MoH RBF initiative

Strategy #3:

Reduce economic barriers

- Harmonize two MH voucher programs
- Assess feasibility of a DBP for priority illnesses among the poor

Strategy #4:

Build public/private capacity in PPP/Hs

- Foster greater understanding and awareness on PPP/Hs
 - Disseminate widely PSA findings and recommendations and present international and local experience on PPP/Hs
- Strengthen PPD and coordination at national and regional levels by
 - Embedding PPP/Hs in HPAC and strengthen its capacity coordinate across the sectors
 - Building private capacity to dialogue with MoH and to participate in policy and implementation
- Invest in building PPP/H Node's capacity to implement PPP/Hs
 - Fully staff and train Node in needed expertise
 - Draft PPP/H implementation guidelines and build operating systems
 - Assist PPP/H Node to generate information on private sector activities

Strategy #5:

Broker and Implement in PPP/Hs

- Provide T/A to Node to broke 1st and 2nd generation of PPP/Hs
- Implement low risk/low cost PPPs- coordinate vaccine delivery and coordinate ambulance services, establish public-private referral systems, share information, extend service contracts in select health areas (primary and specialty)

Low Hanging Fruit 1 - 2 years

Strategy #1:

Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
 - Strengthen private sector reporting to the MoH
 - Assist MoH and professional associations/NMGs use data to inform policy, programs
- Streamline and institutionalize SQIS
 - Build MoH capacity to interpret and report on status of quality in private sector
 - Assist MoH and professional associations, NMOs to use data to improve quality
- Separate and build HRH policy and planning function in the MoH
- Improve HRIS
- Strengthen and harmonize professional associations
- Streamline and strengthen regulatory agencies and councils
- Move towards 3rd party co-regulation of quality
 - Convey legal authority to NMOs
 - MoH and NMQs work together to establish roles/responsibilities and operating systems, conduct joint visits

Strategy #2:

Create financial incentives to attract private sector to partner with MoH

- Create institutional arrangements/operating systems for provider payment mechanisms
 - Build Node's capacity to apply tools (e.g. contracting, RBF, vouchers, etc.) in various PPP/Hs

Strategy #3:

Reduce economic barriers

- Design and roll-out DBF
- Adapt MH voucher for urban setting, include CH m benefit packages and roll out to urban poor
- Use financial mechanisms to organize and structure private sector in key health markets
 - Compel private providers and private pharmacies/drug shops to join a NMO
 - Provide TA to NMOs to become viable and financially sustainable network managers

Strategy #4:

Build public/private capacity in PPP/Hs

- Intensify dialogue and interactions between the
 - Build gov't entities dialogue and partnering skills
 - Build private sector capacity to unify the private health sector voice
- Establish PPP/H Coordinating Committees at the District Level
- Invest in building PPP/H Node's capacity to implement PPP^Hs
 - Train and mentor Node staff skill areas as they broker PPP/Hs
 - PPP^H Node continues to generate data to inform policy and planning

Strategy #5:

Broker and Implement in PPP/Hs

- Implement moderate risky medium costs PPPs- Service contracts with provider NMOs for Urban Poor MH Voucher and pharmacy NMOs under DBP, Down-referral PPP/H for HIV/AIDs purchase commitments to locally manufacture ORS/ZINC/fortified food, co-location of private lab outsource non-clinical services

Long Term Gains 2 - 4 years

Strategy #1:

Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
 - Continue strengthening private sector reporting to the MoH and assisting MoH and professional associations/HMOs to use data to inform policy and programs
- Stream line and institutionalize SQIS
 - Continue strengthening MoH capacity to analyze and report on Status Of quality in private second assisting MoH and professional associations/NMOs to use data to improve quality
- Continue to strengthen MoH HRH policy and planning function in the MoH
- MoH and NMOs work together to monitor quality in private sector

Strategy #2:

Create financial incentives to attract private sector to partner with MoH

- MoH has fully functioning institution and operating systems for provider payment mechanisms
- MoH uses financial mechanisms to further organize and structure private sector
 - All PPP/H compel private providers and private pharmacies/drug shops to join and
- Support NMQs To manage government contracts

Strategy #3:

Reduce economic barriers

- MoH scales DBP nationwide
- MoH scales RBF to purchase services and goods from PNFP and PHPs
- MoH move MCH voucher program management to Ugandan institutions

Strategy #4:

Build public/private capacity in PPP/Hs

- Foster opportunities for PPD and coordination
 - Support PPP/H Node to convene various policy forums, mobilize private sector in policy and planning and coordinate public-private resources
- Support PPP/H Node, as needed, to implement complex PPP/Hs

Strategy #5:

Broker and Implement in PPP/Hs

- Build on experience with moderate risk/medium costs PPPs to implement high risk/cost infrastructure and MES PPPs- Increase # of service contracts to outsource non-clinical services; Expand # of service contracts with provider NMOs to scale MCH Voucher Program and pharmacy NMOs under DBFs to scale nationwide; Increase # of down-referral contracts for HIV/AIDs and expand to NCDs; Expand # of private lab co-location in MoH facilities; Lease medical equipment/ambulances: Implement a MES for limited # of Neo-Natal units and Operating Theatres and # of infrastructure PPP To manufacture oxygen and/or establish a national EMRS

10.4. Way Forward

The Uganda PSA has already accomplished much with an expressed commitment to partnership from stakeholders in both the public and private sectors and a strong policy foundation to enable public-private collaboration. The PSA Advisory Committee as well as a wide arrange of public and private stakeholders have reviewed and validated the PSA findings, recommendations and strategic priorities during an in-country dissemination workshop on June 8, 2016. In addition, the MoH had conducted a comprehensive review to ensure accuracy of the data and to vet the PSA's recommendation internally. In fact, both the MoH and private sector groups have already taken actions based on the PSA recommendations. The MoH PPP/H Node has achieved consensus on a Five Year Strategic Plan for PPPs in Health – the first ever in the history of Uganda. The Plan's strategic directions are closely aligned with many of the recommendations proposed. The MoH has invited key private sector groups, such as UHF, to participate in HPAC and PPP TWG. In addition, private sector groups, such as UHF and UPMA, along with the Medical Bureaus, are further organizing their constituencies and actively advocating and influencing health policies. By seizing existing partnership opportunities and fostering a health system that leverages the skills, resources, and talents of all health actors, the goal of delivering accessible and high-quality health care to all Ugandans is achievable.

There are data and information gaps that would need to be filled if the PSA is to be a continuously updated document useful for programming in the health system. The observed gaps are:

1. More research is needed to understand the scope, coverage and contribution of TCMPs to the health sector.
2. A cost of services analysis.
3. Analysis of the magnitude and cost of private health services within public institutions.
4. Services needs analysis to understand the availability of services and the distribution of health facilities within the areas.
5. Determining the mismatch between the community health services needs and the availability of services within the public and private health facilities in that area.
6. Assessment of the competency and quality of service providers from public and private HTIs.
7. More research is needed to determine the appropriate information system structuring that suits both the public and private sector.

ANNEXES

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2 Annex II: PSA Advisory Committee Composition and SOW

The first PSA stakeholders’ meeting brainstormed and proposed a composition of people and or organizations to form the advisory committee. The committee was chaired by the Commissioner Health Services, Planning MOH with representation from the public sector, private sector and development partners as detailed below. The committee reports to the Director General, Health Services.

Public Sector	Private Sector	Development Partners
<ol style="list-style-type: none"> 1. Dr. Sarah Byakika, Commissioner Planning, MOH – Chair 2. Hannington Ashaba, Commissioner PPP unit, MOFPED – Vice Chair 3. Dr. Daniel Okello Ayen– KCCA 4. Dr. Timothy Musila, Head, PPP Node 5. Sandra Kebirungi – PPP Node 	Private for profit (PFP) <ol style="list-style-type: none"> 1. UHF- Grace Kiwanuka 2. PFSU 	<ol style="list-style-type: none"> 1. USAID 2. DFID 3. SIDA 4. WHO 5. WB /IFC 6. Belgian Technical Cooperation
	Private not for Profit (NFP) <ol style="list-style-type: none"> 1. Uganda Catholic Medical Bureau- Dr. Sam Orach 2. Uganda Protestant Medical Bureau- Dr. Patrick Kerchan 	

2.1 Advisory Committee Scope

The Advisory Committee plays a critical role in building country-ownership of the PSA and political support to implement the PSA’s recommendations. Per the PSA process, a description of the Advisory Committee’s scope and activities is organized by the five stages of a PSA initiative.

1. **Plan and organize the PSA.** Tasks involved: i) forming an Advisory Committee comprised of public, private and development partner stakeholders (less than 1); ii) securing government approval and support to conduct a PSA and assign staff to participate; iii) finalizing the PSA technical scope; iv) reviewing the list of documents for the literature review and assisting the PSA team collect them; v) assisting the local PSA technical team to develop the list of stakeholder interviews and facility visits; and vi) facilitating access to the stakeholders to be interviewed.
2. **Collect data to learn about the private sector.** The Advisory Committee served as a sounding board for the technical team, particularly in interpreting the findings and grounding the recommendations to Uganda’s context. As available, Advisory Committee members participated: i) sending a representative to the one-day training on PSAs; ii) in strategic/key stakeholder interviews; and iii) in a few site visits. Any Advisory Committee member was also invited, but not obligated, to attend any of the nightly sessions interpreting the day’s findings. At the end of the two-week first round field trip, the Advisory Committee convened and attended a three- hour debriefing meeting with the PSA technical team to discuss the preliminary findings and plan for next steps.
3. **Analyze the data collected.** The analysis stage was an iterative process in which the PSA technical team engaged the Advisory Committee in several key junctures to discuss and validate the findings. The first point was towards the end of the January exercise (See Stage 2) to present its first impressions. Second, the Advisory Committee participated in the second round of data analysis. Third, the PSA team members updated the initial presentation with the data from the field and convened a meeting with the Advisory Committee to discuss any revisions based on the field data collection. Fourth, the Advisory Committee reviewed and commented on the 1st draft of the PSA.
4. **Validate the findings.** The Advisory Committee’s role changed significantly in Stage 4 as they assumed responsibility for prioritizing PSA recommendations, identifying how and who will implement them, and creating the political support for the recommendations which became the “Blue Print” for action.

Also during this stage, the PSA team assisted the Advisory Committee to: i) prepare for the panel and presentation at the EAHF Conference, ii) design and carried out a validation workshop and iii) promoted and marketed the Workshop and raised awareness on the public-private commitment to work together in specific areas. The advisory committee later recommended an external consultant to review the second draft a process that yielded the final draft.

5. **Act on the PSA recommendations.** At the initial dissemination workshop, the Advisory Committee took a leadership role to build consensus on a priority list of key actions for both the government, private sector donors and to bring on board more public and private sector representatives to form a larger, more representative body that will drive and monitor implementation of the Private Sector “Blue Print”.

3 Annex III: Final PSA Scope of Work



Uganda Private Sector Assessment Scope of Work

3.1 Background

The USAID/Uganda Private Health Support Program is USAID’s flagship program in the private sector in Uganda. Built on the successes of USAID’s Health Initiatives for the Private Sector (HIPS) Project, the Program is designed to leverage the private sector’s strengths while addressing longstanding concerns about its capacity, quality and interests. The USAID/Uganda Private Health Support Program (herein referred to as PHS Program) aims to strengthen, organize and mobilize the private sector to provide Ugandans with the option of obtaining high-quality health services from private for profit (PFP) providers. This supports USAID/Uganda’s 2011-2015 Country Development Cooperation Strategy (CDCS), in particular Development Objective 3 (DO3), where three of the four sub-results under Intermediate Results (IR) 3.1 (IR3.1.2, IR3.1.3 and IR3.1.4) align well with leveraging and expanding the existing capacity of the private sector.

The goal of the PHS Program is to improve the credibility and cohesiveness of the private sector and expand the capacity of private sector providers. The focus of its support is to provide technical expertise, enhance quality standards, improve access to capital, support accreditation and provide leadership in the private sector. In order to achieve this, the Program has three main objectives: 1) Expanded availability of health services by private providers; 2) Increased affordability of private health services and products; and 3) Improved quality of private health sector facilities and services.

Box 1. Why would having a PSA in Uganda be useful?

- To generate data for planning by government and donors on activities with private sector
- To better understand the relevance of the private sector in the health system
- To identify gaps in the public health system that the private system may address
- To consolidate the most relevant literature and data on the private sector into a single document
- To guide private sector contribution in provision of healthcare
- To recommend how GOU and development partners can harness the private health sector

Clearly, the Private Sector Assessment is instrumental in helping the PHS Program assess the private sector’s full potential in achieving the program’s three objectives as well as developing a “blue print” to harness its prospects. Other development partners, such as the World Bank Group’s Health in Africa Initiative (HIA) and the Global Financing Facility (GFF) committed funds to the PSA. The Belgian Technical Cooperation (BTC) has also expressed an interest in co-sponsoring the PSA. Table One notes several reasons for conducting a PSA⁷⁵.

This scope assumed full participation from all four development partners – USAID/Uganda, HIA, and GFF– which had implications of the PSA’s scope and breadth. With full co-sponsorship, the PSA team was able to carry out a wider scope and cover greater geographic areas in the PSA research and report.

⁷⁵ As small group on Ugandan leaders from the public and private sector, with assistance from the PHS Program, meet to discuss the purpose of a PSA.

3.2 Objectives

The primary objectives of the activity was three-fold:

- To document and develop a comprehensive picture of private sector activities throughout the health system in Uganda
- To identify potential areas for the Ugandan private health sector to contribute to Ministry of Health goals and objectives as outlined in HSSP IV
- To propose a road map to harness private sector potential to address a select number of strategic health areas and/or health systems gaps as outlined in the MOH Public-Private-Partnership Policy and Strategy

At the December 3, 2015, meeting, the group also formed an Advisory Committee to inform and guide the PSA technical team throughout the assignment. They discussed and agreed on a preliminary scope of the technical areas to be examined in the PSA (See box 2). The group preferred to do a comprehensive scope in terms of both health issues and health system areas as well as geographic reach. In terms of health issues, the group proposed the PSA examines the health areas outlined in the MOH's minimum healthcare package, emphasizing maternal/reproductive health, newborn/child health, and HIV/AIDS. Although the group liked the PSA to examine all the health system building blocks, health financing and medical supplies were identified as priority areas. Also, the group recommended the PSA cover the entire country to determine the difference between urban and rural areas in market reach of the private sector.

Box 2. What the scope of the PSA was

Guiding principles

- Comprehensive scope bounded with health priority areas and guided by health policies in place
- Framed by the SDGs
- A strong private sector is a viable contributor to addressing health sector needs

Priority areas

- Geographic focus – sample to reflect variance in urban and rural areas
- Health domains/areas – MoH minimum healthcare package
- Health systems areas – building blocks (health financing, HRH, medical supplies, leadership and governance, HMIS)

3.3 Technical Focus Areas

The Advisory Committee had initially identified the following technical areas to be researched in the PSA. They included:

- Policy supporting and governance of private health sector
- Health financing issues as it relates to private health sector
- Size and scope of private supply chain
- Private sector delivery of key health services, including HIV/AIDS, TB & Malaria, Family Planning/Reproductive Health, and Maternal/Child Health.

Although the Advisory Committee wanted to include other “building blocks” and health areas, the team agreed to ask a few additions questions but not have comprehensive analysis of HRH, HMIS and chronic diseases.

3.4 Key Assessment Questions

Below is a list of research questions that the PSA team addressed:

Policy supporting and governance of private health sector

1. What is the MOH policy regarding public-private collaboration? How well is being implemented?
2. What is the relationship between public and private health sectors? How and where do they interact to discuss sector wide issues?
3. What regulatory and policy factors most impact how the private health sector contributes to public health goals?
4. How does the private sector govern, lead, and advocate for itself?
5. Are there existing examples of PPPHs? How well are they working? What challenges are there to implement PPPHs?
6. What is government capacity to regulate and govern the private health sector? What constraints and challenges does it encounter in regulating the health sector?
7. How can the private sector contribute to national health information systems in order to promote strong transparency, surveillance, and good governance?

Health financing issues as it relates to private health sector

1. What health financing policies and programs most impact how the private health sector contributes to public health goals? In particular, is the PHC Basket an effective mechanism to finance FBOs?
2. How do donor funds influence the private sector's ability or motivation to contribute to the public health?
3. How would the health financing initiatives, RBF and GFF, influence private health sector?
4. What are the possibilities of NHIS in the near future? How would impact private health sector?
5. What are key opportunities for the private sector to increase their fiscal contribution toward public health?
6. Is private sector health insurance a viable option for increasing financial protection from health expenditures?
7. What lessons may the private sector share with the public sector around using financial mechanisms to motivate quality and access?

Size and scope of the private sector supply chain

1. Who are the key stakeholders in the private sector health product supply chain? What challenges do they confront in current market conditions?
2. Can local manufacturers of health products a viable option?
3. What challenges and opportunities face private sector supply chains to best coordinate with the GOU public supply chain to promote an efficient system?
4. Are there opportunities for PPPH between the public and private sectors to reduce wastage and increase inefficiency?

Private sector delivery of key health services, including HIV/AIDs, TB & Malaria, Family Planning/Reproductive Health, and Maternal Health

1. What is the size and scope of private health sector throughout the health system?
2. Where the private health is sector most active? Why?
3. Who are the private sector stakeholders that deliver key health services?
4. What are the challenges they face in terms of sustainability and capacity to deliver high quality care?
5. What are PPPHs opportunities to harness private sector capacity in key health areas such HIV/AIDs, TB and Malaria, FP/RH and MCH? Under what conditions would the private sector deliver these services?
6. What are opportunities to leverage donor funds financing key health services in order to increase private sector delivery in these key health areas, to improve private health sector quality and facilitate greater reporting to DHIS2?

3.5 Approach

The PSA team adapted the approach developed by USAID called “Assessment to Action” (<http://assessment-action.net/>). A detailed description of the activities and time are in Appendix III. It is important to note that the Advisory Committee presented the preliminary findings of the PSA at the East Africa Healthcare Federation conference held during June 2016. This deadline accelerated the work plan but was feasible given the active participation of the Advisory Committee.

The approach entailed the following five steps. The adaptations are highlighted in the discussion.

- 1. Planning and organizing the PSA.** As noted before, the PSA team planned for the workshop and convened its first meeting to form an Advisory Committee. The Advisory Committee finalized the PSA technical scope as well as identified key documents for the literature review. The Advisory Committee also finalized the technical composition of the PSA team based on the technical scope and later facilitated the stakeholder interviews.
- 2. Collect data to learn about the private sector.** The PSA team scheduled to travel to Kampala from January 18th to 30th to conduct the stakeholder interviews, gather and review the literature, and develop preliminary findings on the private health sector. The PSA team, in consultation with the Commissioner of the Department of Planning agreed on the stakeholder methodology. The data was collected over a 2-month period with the January trip as the kick-off. The PSA team conducted all the KCCA related interviews in the first two weeks. During the months of February and March, the team I travel to 5 regions (following the geographic division used in the DHS) to interview a subset of the stakeholders in both an urban and rural setting.

On average, a PSA team conducted upwards of 30 interviews per technical focus area (6 total x 30 = 180). Stakeholder profile in the public sector ranged from top level MOH officials, MOH mid-managers and Councils as well Ministry of Finance top- and mid-level managers. On the private sector side, stakeholders included professional association, trade associations, and individual private providers representing a wide range of health facilities and supply chain operations. Donors and their implementing partners rounded out the stakeholder interviews. More weight (e.g. number) was given to private providers and their representative bodies.

- 3. Analyze the data collected.** The analysis stage was an iterative process in which the PSA technical team engaged the Advisory Committee in several key junctures to discuss and validate the findings. The first point was towards the end of the January exercise. The PSA technical team developed and presented its first impressions. Similarly, the Advisory Committee participated in the second round of data analysis. Afterwards, the PSA team updated the initial presentation with the data from the field and convened a meeting with the Advisory Committee to discuss any revisions based on the field data collection.

In addition, the PSA technical team wrote their respective sections. The team leaders were responsible for integrating and synthesizing all of the sections during that stage. Once there was a first draft, the entire PSA technical team reviewed and provided comments before submitting it to the Advisory Committee.

- 4. Validate the findings.** Another adaptation of the PSA approach was the inclusion and participation in the validation of the PSA findings. The Advisory Committee played an active role in: i) reviewing and commenting on the PSA’s 1st draft; ii) strategizing on how to disseminate the preliminary findings among key stakeholders in both the public and private sectors to build support; iii) brainstorming on recommendations to address the findings and to become the blue print for action; and iv) led the dissemination efforts including the presentation / panel at the EAHF Conference and PSA first Dissemination Workshop. During this stage, the PSA team worked with the Advisory Committee to prepare for the panel and presentation at the EAHF Conference and designed and carried out a validation workshop. After the first Dissemination Workshop, the PSA technical team I revised the findings and finalized the recommendations based on the Workshop’s agreements. Also, the PSA technical team I worked with the Advisory Committee to promote and market the Workshop and to raise awareness on the public-private commitment to work together in specific areas.

5. **Act on the PSA recommendations.** Emerging from the PSA Dissemination workshop a priority list of key actions for both the government, private sector donors was taken. Additionally, the Workshop participants identified a core group to continue the process to further refine the Private Sector “Blue Print”, garner political support and funds to implement, and monitor progress on its implementation over the course of the next years. At this point the PSA technical team will close its activities and hopefully the Advisory Committee, with support from government agencies and development partners will implement the Private Sector “Blue Print”.

Preparatory Materials

With assistance from the PSA technical team, the Advisory Committee, provided the team a list of background and other relevant materials to be duplicated and distributed to PSA technical team members prior to the field exercise in January. Appendix III contains a suggested list of documents that the Advisory Committee reviewed and finalized.

Timeline

The Advisory Committee agreed to present preliminary findings at the East Africa Healthcare Federation to be hosted by UHF in June. As a result, the PSA was conducted in the over the next six months to meet that deadline. The PSA first dissemination workshop occurred just after the EAHF event.

Deliverables

The PSA scope of work will produce the following deliverables

- Final scope of technical areas for the PSA (January 31)
- List of stakeholders and site visits completed (February 28 2016)
- Draft presentation two) on preliminary PSA findings (1st - January 31, 2nd – April 1st 2016)
- 1st, draft of the PSA technical report (April 1st)
- 2nd draft of PSA technical report (June 8th) for EAHF Conference
- Technical presentation for EAHF Conference (June 8th)
- Dissemination workshop (June 15th)
- Integration of comments into final draft (August 15th)
- Validation of the report (November 15th)
- Final copy edit (December 15th)
- Final PSA report with private Sector “Road Map for Action” (January 15th 2017)
- Dissemination/Launch of final report (February 10th 2017)

Outcomes

- Capacity to analyze data on the private health sector
- Government is equipped with information required to inform MOH policy initiatives, MOH management, and donor programs to leverage private sector capacity
- Government recognition of the private sector current contribution to health and identification of strategic areas to further leverage its potential
- Widespread support among both key public and private stakeholder groups to work together on the Blue Print for Action

4 Annex IV: PSA Activities and timeline

Task/	Work Plan Activity
Time Frame	
Step 1: Plan and Organize the PSA	
December 2015- January 2016	1. Secure PPP-TWG agreement
	2. Form Advisory Committee comprised of public and private sector leaders
	3. Convene a meeting with the Advisory Committee to:
	Finalize scope of PSA
	Develop list of stakeholders to be interviewees and sites to be visited
	4. Identify and gather local documents and references
	5. Adapt and finalize interview guides according to stakeholder groups
	6. Set up site visits and interviews
Step 2: Collect data to learn about the private sector	
12/1 to 1/15	1. Conduct literature review PRIOR to field trip
	2. Conduct secondary analysis of DHS and SPA (if available)
1/15 to 1/30	3. Team travels to Uganda to conduct interviews
	4. Team conducts site visits
	5. Team conducts nightly recaps of days interviews and site visits to develop initial findings
	6. Team debriefs Advisory Committee on initial findings and brainstorms on recommendations
2/1 – 3/30	7. Conduct second round of stakeholder interviews and site visits in areas outside of KCCA
Step 3: Analyze Data	
2/1 to 2/15	1. Team members analyze own data collected prior to field trip
2/15 to 3/15	2. Team members write individual writing assignments
3/15 – 4/15	3. Team leaders synthesize and integrate sections
	4. Team develop 1st draft of PSA
4/15 - 5/30	5. Team conducts internal review of 1st draft of PSA
Step 4: Share the PSA and Validate its Findings and Recommendations	
5/1-5/30	1. Circulate draft and Ex Summ with Advisory Committee
	2. Convene meeting of Advisory Committee to solicit feedback on PSA draft
	3. Encourage Advisory Committee members to discuss PSA findings with own leadership
	4. Organize Dissemination Workshop
Present at EAHF meeting	5. Organize Panel of Advisory Committee Members to present PSA at EAHF Workshop
	6. Circulate Ex Summ to wider stakeholder group attending Dissemination Workshop
Workshop in June	7. Convene Dissemination Workshop
	8. Promote and market (e.g. PR) Dissemination Workshop
Finalization of the report (July-December)	Integration of comments into final draft
	Validation of the report
	Final copy edit
	Final PSA report with private Sector “Road Map for Action”
	Dissemination/Launch of final report
Task 5: Act on Recommendations Emerging from Dissemination Workshop	
After workshop activities continue	1. Help form a wider committed that serves as the basis of a PPD Forum
	2. Facilitate one to two activities that emerged from Dissemination Workshop
	3. Convene PPD members regularly

5 Annex V: PSA Team composition and Contribution

Name / Area	Policy	HCF / A2F	Labs	Supply Chain	HIV/ AIDS	MCH/ RH/FP	HRH	Other Tasks
Barbara O'Hanlon	LEAD	X		X			X	Tech Lead- Lead writer
Rebecca Husband				X	Lead			Co-writer
Dithan Kiragga	X				X			
Angellah Nakyanzi	X				X	X	Lead	Co-writer- Lit review/ HRH/ Scheduling/ Report editing
Robert Okumu			Lead	X				Lab visits
Ivan Busulwa		X		Lead				Scheduling
Abias Asimwe				X				Pharmacy audits
Joy Batusa			X		X	X		Focus on associations
Francis Zikusooka		Lead						
Sneha Kanneganti					X			
Bernard Olayo	X	X				X		
Nelson Gitonga		X						Backstop HCF Co-writer
Henry Musinguzi			X					Pharmacy audits
Veronica Musembi						Lead		Backstop on MCH/RH Co-writer
Sandra Kebirungi	X							Regional field visits
Sarah Byakika	X				X			Report review and validation
Timothy Musila	X	X						Report review
Didas Namanya			X					Regional field visits
David Odongo								Data Analyst

6 Annex VI: PSA Uganda Stakeholders

Kampala Key informants

Interviewee	Designation	Interviewee	Designation
Dr. Henry Mwebesa	Commissioner QA & Acting Head of Department, Planning	Dr. Bildad Baguma	Executive Director, Joint Medical Stores
Dr. Sarah Byakika	Commissioner Planning	Samuel Lee	Program Manager, CHAI
Aliti Tom	Planning Department,	Michael Maynard	Executive Director, Quality Chemicals Uganda
Enyaku Rodgers	Planning Department	Joyce Tamale	Executive Director, Uganda Health Marketing Group
Dr. Henry Mwebesa	Planning Department	Byekwaso John	Chief Operating Officer, Lancet Laboratories
Aliti Tom	Planning Department,	Dr. Iga Matovu	Owner, Kampala Imaging Centre
Enyaku Rodgers	Planning Department	Stephen Kiyimba	Owner, Ebenezer Laboratories
Ali Walimbwa	Planning Department	Grace Ssali	Executive Director, Uganda Health Federation
Caroline Kyozira	Director, Resource Centre	Geoffrey Bulayi	Program Coordinator, Uganda National Association of Private Hospitals
Dr. Timothy Musila	Director, PPPH Node	Dr. Fred Bisso	President, Uganda Medical Association
Dr. Ssendiyona Martin	Quality Assurance Department	Dr. Kenya Mugisha	Immediate Past President, Uganda Medical Association
Joshua Musinguzi	Program Manager, Aids Control Program	Dr. Patrick Kerchan	Head of Programs, Uganda Protestant Medical Bureau
Simon Mwima	Aids Control Program	Sam Orach	Executive Secretary, Uganda Catholic Medical Bureau
Thomas Obua	Pharmacy Division	Dr. Karama Said	Executive Secretary, Uganda Muslim Medical Bureau
Mr. Ayisu	CPHL	Dr. Peter Kawanguzi	President, Uganda private Medical Practitioners' Association
Sulaiman Ikoba	CPHL	Dr. Cephas	Sims Medical Centre
Mark Tumwine	Uganda Virus Research Institute	Dr. Zam Nalule	Life Link Medical Centre
Samuel Kiirya	Joint Clinical Research Centre	Bukenya Miradih	Busabala Nursing home
Frank Mugabe	Program Manager, TB Program	Stephen Mukisa	Span Medical Centre
Dr. Mutungi Gerald	Program Manager, Non-Communicable Diseases	Herbert Kinobere	Community Health Plan
Dr. Dinah Nakiganda	Head of Department, Maternal Health/ FP Department	Stephen Mukisa	Span Medical Centre
Dr. Makanga Livingstone	Maternal Health/ FP Department	Fred Keays	Galilee Community General Hospital
Dr. Daniel Okello Ayen	Deputy Director Health Services- KCCA	Amina Kabuye	Case
Dr. Joel Okullo	Chair, Uganda Medical and Dental Practitioners' Council	Sr. Florence Namazzi	Mukwaya General Hospital

Interviewee	Designation	Interviewee	Designation
Dr. Katumba Gubala	Registrar, Uganda Medical and Dental Practitioners' Council	Kato Sulaiman	Gwatiro
Kasagga Aloysiuos	Chair, Allied Health Professionals' Council	Dr. Faizo Kazibwe	Old Kampala
Mpiima Kibirango	Registrar, Allied Health Professionals' Council	Hanna Baldwin	Executive Director, PACE
John Wakida	Registrar, Uganda Nurses' and Midwives Council	William Nyombi	Marie stopes Uganda
Neville Oteba	Registrar, Pharmacy Council	Dr. Nsubuga Yosam	Doctors Clinic Seguku
Hannington Ashaba	Commissioner PPPs, Ministry of Finance and Economic Development	Dr. Edith Namulema	Mengo Hospital
Orono Otweyo	PPP Unit, Ministry of Finance and Economic Development	Ronnie Mukisa	Meeting point Kampala
Kananura Chris	Executive Director, Insurance Regulation Authority	Sr. Fiona Nalwanga	Holy Cross Namungoona Hospital
Basil Ajer	Ag Executive Director, Uganda Investment Authority	Grace Murindwa	Health Systems Specialist, IFC
Eva Nakimuli	Senior National Program Officer, Population Secretariat	Bernard Olayo	Uganda Program Manager, IFC
John Ampeire Kaijuko	National Program Officer, Population Secretariat	Fillipo Curtale	Health Sector Advisor, BTC
Paul Lubega	Senior Manager Credit, Centenary Bank	Galbert Fedjo	Program Manager, BTC
Annette Kihuguru	Executive Director, Ecobank	Anne Lindeberg	Health Officer, SIDA
Johnson Galabuzi	Head (Local Corporates & SME Domestic Bank), Ecobank	Momuna Henrick	Uganda Program Manager, Cordaid
Jane Mukulu	Head, Access Mobile	Anne Akia Fiedler	Executive Director, FHI 360
Robert Basaza	Independent Consultant	Vincent Oketcho	Executive Director, CAPACITY
Grace Murindwa	Health Systems Specialist, IFC	Birna Trapp	Chief of Party, SURE Project

Regional Interviewees

Interviewee	Designation	Interviewee	Designation
Dr. Bwera Amooti Kaguna	DHO, Mbarara	Edmond Eobu	Administrator, Katakwi Joint Medical Centre
King Emmanuel	In-charge/ Clinical Officer, The Physicians Medical Clinic	John Baptist Waniaye	DHO, Mbale
Dr. Mugenyi G.Rwambuka	Medical Director/Administrator, Devine Mercy Hospital	Jessica Atai	Deputy CEO, Mount Elgon Hospital
Sarah Korutako	Administrator, Devine Mercy Hospital	Dr. Wakamuke Elijah	Consultant Radiologist, Mount Elgon Hospital
Eric Thekeronga	Lab Technologist, Devine Mercy Hospital	Eric Nangosya	Administrator, Mount Elson Hospital
Dr. Nakiswa Rose	Medical Officer, Mbarara Community Hospital	Madoi Ayubu	PPPH Focal Person, Mbale
Mugaiga Kenneth	Administrator, Mbarara Community Hospital	Margret Muiyi	Dispenser, Bushikori HC III
Arinaitwe Angello	Lab Technician, Mbarara Community Hospital	Bisikwa Florence	Ass Incharge/CO, Bushikori HC III
Mugabe Owen	Lab assistant, Mbarara Community Hospital	Anena Jennifer	Nursing officer, Bushikori HC III
Velenah Tumuhairwe	Nurse, Golden Seal Pharmacy	Herbert N.	Manager. Gilead Pharmacy
Justus Aryeija	Clinical Officer/Owner, Rwiza Medical Clinic	Peter Chemayek	EN/dispenser , High life Pharmacy
Tugaine Matsiko	Owner, Tugaine- Matsiko Drug Shop	Kahendeke susan	Nurse , Trendz Pharmacy
Rwabwijaju Eric	Owner, Drug shop-Kinoni	Rashid Chelogoi	Nursing dispenser, Jary Pharmacy
Tumukunde Afisa	Medical Assistant, North Ankole drug shop	Dr. Nabangi Charles	DHO, Mayuge
Innocent Mugume	Medical Officer/Owner, Family Health Resource Centre	Dr. Kalende Henry	Medical Superintendent, St. Francis Buluba Hospital
Dr. Ambrose Katwire	Medical Director, Kyotera Medical Centre	Sr. Josephine Namugerwa	Pharm In charge, St. Francis Buluba Hospital
Kato Charles	In-Charge, St. Cecilia Buyamba Health Centre III	Babirye Oliver	Owner, Ikanza Pharmacy
Musakuwona Mary Gorette	Lab Assistant, St. Cecilia Buyamba Health Centre III	Nanzige Mary	Lab assistant, Sam Medical Centre

Interviewee	Designation	Interviewee	Designation
Nankabirwa Ritah	Nurse, Byansi Pharmacy	Sam Tangahye	Owner/Psychiatric Clinical Officer, Sam Medical Centre
Dr. Musisi Stuart	DHO, Masaka	Onyanga Joseph	Director/CO, JK Pancrass Medical Clinic
Opio Martin Otyek	Medical Director, Kitovu Hospital	Yusuf Nkanda	Pharm Incharge, JK Pancrass Medical Clinic
Dr. Jjunju Luwaga	Owner, All Saints Clinic and Lab	Ritah Namisango	EN/Dispenser, Sam Medical Centre
Namazzi Aidah	Sales Manager, Masaka Pahrm Ltd	Fred Ndikolaki	Enrolled Nurse, True Image Medical Centre
Nansubuga Agnes	Registered Nurse, Lugoba Pharmacy	Dr.A.K. Singh	Medical Superintendent, Kakira Sugar Hospital
Godfrey Okwi	District Drug Inspector, Katakwi	William Eriwala	Pharmacist, Kakira Sugar Hospital
Acen Mary	Nursing Assistant, Katakwi COU HC II	Bwire Nehemia	Lab Technician, Kakira Sugar Hospital
John Robert Irangolet	Clinical Officer, Katakwi COU HC II	Gilbert Baayenda	District PPPH Focal Person
Sr. Anna Christine Auma	In charge, Usuku HC III	Sr. Benedacta Yeo	In charge, St. Benedict HC
Adiang Angellah	Nursing Assistant, USUKU HC III	Janet Luwemba	Enrolled Nurse, St. Benedict HC
Mike Rugunda	Clinical Officer, D'ACE Med&Women Clinic	Opwonya John	PPPH Focal Person, Gulu District
Dr. Angella Namala	Medical Director, D'ACE Med&Women Clinic	Berochan Ceaser	CO/In charge, St. Monica HCII
Judith Namudope	Nursing Assistant, D'ACE Med&Women Clinic	Acire Ronald	CO/In charge St. Mauritz HCII
Denis Byayi	Dispenser, Green Pharmacy	Onyach George	Lab Assistant, St. Mauritz HCII
Adero Denis	Dispenser, Gilead pharmacy	Akello Mercy	ECN/ St Monica HCII
Emmie	Nurse, BLTIM Pharmacy	Zafar Ahmad	Marketing Manager, Lira Health Care Pharmacy
Zafar Ahmad	Marketing Manager, Lira Health Care Pharmacy	Ahmed	Manager, Zee Pharmacy Manager
Ahmed	Manager, Zee Pharmacy Manager	Odur Daniel Roy	In charge, Charis Medical Center Facility
Odur Daniel Roy	In charge, Charis Medical Center Facility	Odongo Caroline Patience	Administrator, Lira Medical Center
Odongo Caroline Patience	Administrator, Lira Medical Center	Ongom Bonny	Lab Technician, Charis Health Center Technician

Interviewee	Designation	Interviewee	Designation
Ongom Bonny	Lab Technician, Charis Health Center Technician	Ocen Emmanuel Brown	Enrolled Nurse/Dispenser, Lira Medical Center
Ocen Emmanuel Brown	Enrolled Nurse/Dispenser, Lira Medical Center	Omara Walter	ECN/Dispenser, Charis Medical Center
Omara Walter	ECN/Dispenser, Charis Medical Center	Nakafeero Ritah Tamale	In charge/Nurse Coordinator, Gulu Independent Hospital
Obua Isaac Newton	In charge, Boroboro HCIII Facility	Onen Rogers	Administrator, Fitzmann Health Care
Araca Morgan	Lab Assistant, Boroboro HCIII	Alex Okori	Dispenser, Boroboro HCIII

7 Annex VII: PSA Regional Validations

Northern Region	Eastern Region	Central Region	Western Region
Gulu	Mbale	Wakiso	Mbarara
Arua	Iganga	Kyankwanzi	Insiro
Kitgum	Jinja	Sembabule	Lyantonde
Abim	paliisa	Mpigi	Bushenyi
Lira	Soroti	Masaka	Sheema
Nebbi	Serere	Lwengo	Hoima
Pader	Buyende	Rakai	Kabale
Lamwo	Manafwa	Kalungu	Kabarole
Malacha	Busia	Kalangala	Kasese
Zombo	Bukwo	Mubende	Masindi

Regional Validation Participants

MBALE REGION	GULU REGION	MASAKA REGION	MBARARA REGION
Mafabi Michael	Atamango Brenda	Dr. Serebe John Bosco	Baguma Patrick
Duchu Patrick	Droma Morrish	Nassanga JR	Masereka Enos
Mwesigwa Loy	Akello Theresa	Katubi Hamuzah	Dr. Abiriga Jino
Baayanda Gilbert	Caroline Ocheng	Bugimbi Edward	Ariyo Titus
Muwanguzi Patrick	Auma Penninah	Teefe John	Mulinolambune
Dr. Engulu W	Okello Ivan Douglas	Dr. Matovu Charles	Kugonza Fred
Elenyu John	Ayella George Oryem	Bukirwa Beatrice	Mutebi Alfred
Anaso Rosemary	Pachoto George	Kizza Peter	Dr. Kwikiza Nicholas
Nagoola Mariam	Aletiru Stella	Ssematimba G	Nabimanya Esther
Baganzi Moses	Apangu Pontious	Dr. Mubiru Wilson	Dr. Obbo Okoth
Nakwala Joshua	Candribo Sanday	Mukabalisa Joweria	Nzabakuriza Arseu
Mulira Siraji	Kwach Morris	Namukwaya Susan	Kyomugisha Catherine
Nampewo Evarine	Nyakorach Caroline	Bwire William	
Madoi Ayub	Okumu Patrick	Mirembe J. Magoba	
Dr. Satya Collins	Kenyi Santus	Katukwe Andrew	
Somikwo Victor	Okot Margret Ayat	Bakidde Fred	
Sorowon David	Dr. Unyuthu George	Kkande Dinah	
Ekisa Geoffrey	Ongiera Sam Ajoga	Dr. Mutebi Ronald	
Okot Simon Rockfund	Muyomba Ronald	Mayanja Gordon	
Aujo Grace	Jimmy Komakech		
Atingu Joseph	Rackara Emmanuel		
Sajja Geofrey			
Dr. Dyogo Nantamu			