Government of Uganda

National Policy on Public Private Partnership in Health

March, 2012

PREFACE

The ***Government of Uganda*** promote and encourage public-private partnership as a way to achieve economic growth and poverty eradication and intends to strengthen partnership with the ***Private Health Sector***. The present draft policy paper, prepared by members of the Technical Working Group on Public Private Partnership in Health under the guidance of a Steering Committee, is meant to guide this process with the aim to strengthening the national health system and provide the highest possible level of health services.

Part One of the document indicates the general policy framework for partnership with the private health sector as whole. This will form the foundation enabling further development of specific areas of partnership and strategies to make the best use of available resources and utilise the full potential of the three sub-sectors: Private Not-For-Profit health providers, Private Health Practitioners, Traditional and Complementary Medicine Practitioners. This section also include specific indications on the structures the partnership, strategies and tools to institutionalise it, as well as on mediation and arbitration of disputes.

Part Two follows the framework presented in part one, expanding and adapting partnership implementation areas and strategies to the specific requirements of the partnership with the Private Not-For-Profit health providers. ***Part Three*** addresses the partnership framework with the Private Health Practitioners. ***Part Four*** addresses the partnership framework for Traditional and Complementary Medicine Practitioners.

Each sub-sector specific section (*Part Two*, *Three* and *Four* of the document) consists of three major chapters:

- the *first chapter* is a background section, including definition of each sub-sector, organization and structure of coordination, mission, contribution to the health system and existing collaborations,
- the *second chapter* includes the core policy framework for partnership, defining rationale, guiding principles, goal and objectives of the partnership for the sub-sector,
- the *third chapter* presents the areas and strategies of partnership implementation for each sub-sector, which will be further developed in the ***Implementation Guidelines***.

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LIST OF ACRONYMS

AMREF	African Medical Research Foundation
CDD	Control of Diarrhoeal Diseases
CORPs	Community Resource Persons (Community Health Workers)
CoU	Church of Uganda
CBOs	Community-Based Organisations
CSOs	Civil Society Organisations
DDHS	District Director of Health Services
DHMT	District Health Management Team
DSC	District Service Commission
EDMP	Essential Drug and Management Programme
FB-PNFP	Facility-Based Private Not-For Profit
GoU	Government of Uganda
HC	Health Centre
HDPs	Health Development Partners
HMIS	Health Management Information Systems
HPAC	Health Policy Advisory Committee
HPRC	Health Policy Review Commission
HRD	Human Resource Development
HSD	Health Sub-District
HSSIP	Health Sector Strategic and Investment Plan
HUMC	Health Unit Management Committee
IIAM	International Institute of Complementary and Traditional Medicine
JRM	Joint Review Mission
LC	Local Council
LLU	Lower Level Unit
MHCP	Minimum Health Care Package
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning & Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
NACOTHA	National Council of Traditional Healers, Herbalists Association
NARO	National Agricultural Research organization
NCRL	Natural Chemotherapeutic Research Laboratory

NGO	Non-Governmental Organisation
NHA	National Health Assembly
NHP	National Health Policy
NFB-PNFP	Non-Facility-Based Private Not-For-Profit
PDC	Parish Development Committee
PEAP	Poverty Eradication Action Plan
PHP	Private Health Practitioners
PLWA	People Living with AIDS
PNFP	Private Not For Profit
PPPH	Public-Private Partnership in Health
PROMETRA	The Association For Promotion Of Traditional Medicine
RCC	Roman Catholic Church
SCHC	Sub-County Health Committee
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
TCM	Traditional and Complementary Medicine
TCMP	Traditional and Complementary Medicine Practice
TH	Traditional Healers
THETA	Traditional and Modern Health Practitioners Together Against AIDS
TM	Traditional Medicine
UAHPC	Uganda Allied Health Professional Council
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UMDPC	Uganda Medical and Dental Practitioners Council
UNCST	Uganda National Council of Science and Technology
UNEPI	Uganda National Expanded Programme on Immunisation
UNMC	Uganda Nurses and Midwives Council
UNMHCP	Uganda National Minimum Health Care Package
UPC	Uganda Pharmaceutical Council
UPHA	Uganda Private Health Unit Association
UPMA	Uganda Private Midwives Association
UPMB	Uganda Protestant Medical Bureau
UPMPA	Uganda Private Medical Practitioners Association
VHT	Village Health Team

GLOSSARY

Access

The right, opportunity or ability to utilise 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 has 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 a minimum of waste

Identity

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

Managerial Autonomy

Retaining the right to self-government and self-management of the organisation's operations in line with organisational values and norms, while recognising 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

Private

Not belonging to or run by either Central or Local Government

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's meant to serve. Statements are conceived to address a theme, or purpose of actions to society, institutions, and individuals, for present and future guidance

Public

Of either Central or Local Government

Public Health Discipline

Any discipline, in the field of medical science, aiming at reducing the burden of diseases among the population

Public-Private Partnership

The term Public-Private Partnership describes a spectrum of possible relationships between the public and private actors for integrated planning, provision and monitoring of services. The essential prerequisite is some degree of private participation in the delivery of traditionally public domain services

Sector-Wide Approach

A sustained partnership involving Government and Development Partners and other stakeholders in health, with a goal of achieving improvements in people's health and contributing to national development objectives in the context of a coherent health sector through a collaborative programme of work with established structures and processes for negotiating strategic and management issues and reviewing sectoral performance against agreed milestones and targets

Sub-Working Group

A working group, including part of the members of the Working Group on PPPH, representing and coordinating a sub-sector (PNFP, PHP, TCMP)

Sustainability

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

Technical Head of Health Services

A staff of the Ministry of Health responsible for planning and implementing health services in a given area

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

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.

Part One

General Framework for Partnership

with the Private Health Sector

PART ONE

GENERAL FRAMEWORK FOR PARTNERSHIP WITH THE PRIVATE HEALTH SECTOR

The purpose of this document is to provide guidance to mainstreaming, establishing, implementing, coordinating, monitoring and evaluating partnerships between the Government of Uganda and the private health sector within existing laws, policies and plans. This document is a means to achieving the broader national health objectives.

More specifically, the document aims to promote recognition and value of the role and contribution of the private sector in health development; define an institutional framework within which to coordinate, implement, monitor, evaluate and enrich the partnership; guide further development of the specific policies for partnership with the different private sub-sectors; provide policy makers and other stakeholders in health with guidelines for identifying and addressing partnership concerns when taking policy decisions

1. SITUATION ANALYSIS

In order to improve the health status of the people of Uganda, to increase the geographical access to health care, to reduce poverty and illiteracy, that are recognized to be the main underlying cause of the health situation in the country, the government has put in place policies and plans to address health sector development in the medium and long term. One of the areas that government is addressing is ***'partnerships'*** among and between Health development Partners, line ministries/agencies, and private sector stakeholders and providers.

Government collaboration with the private sector has in the past involved various programmes (e.g. CDD, UNEPI, Malaria Control Programme, Global Fund, GAVI) or addressed special needs within the private sector (such as government subsidies to private sector). The Government of Uganda is developing the National Policy on Public Private Partnership in Health (PPPH), in order to build a sustainable partnership with the private health sector and strengthen the health care delivery system.

The government aims to provide an enabling environment for effective coordination of efforts among all partners, to increase efficiency in resource allocation, achieve equity in the distribution of available resources for health and effective access by all Ugandans to the Ugandan National Minimum Health Care Package (UMHCP).

The development of the National Policy on PPPH is guided by the 1995 Constitution of the Republic of Uganda stating, among its political objectives, encouragement and promotion of private initiative and self-reliance in order to facilitate rapid and equitable development, and the liberalization policy, which give strong incentives for government to collaborate with, and support private initiative in health service delivery.

The National Development Plan (NDP) 2010/11-2014/15 stresses the role of the Government in promoting and encouraging public and private partnership in all sectors of national development, and in particular in the health sector, to effectively build and utilize the full potential of the public and private sector in Uganda's national health development.

Both the National Health Policy (NHP) I° (1999), and the NHP II° (2010) acknowledge the role of the private sector in health and the need of a National Policy to provide a legal framework for linkage of the public and private sectors. The establishment of a functional integration between the public and private sectors, in health care delivery, training, and research, is considered as an important strategy for strengthening health systems.

The Health Sector Strategic and Investment Plan (HSSIP) recognizes that effective provision of the Uganda National Minimum Health Care Package is not only the responsibility of the Ministry of Health and Partnership with the private sector is a critical determinant of the successful implementation of the Plan. It stresses the urgency for the Government, over the next five years of the HSSIP, to strengthen partnerships with all stakeholders and strengthen the policy and legal environment, conducive for PPPH, in order to achieve the set objectives.

1.1 The Public Health Sector

The public health care system has undergone transformation over the last several years as a result of proactive policies instituted by government. Health infrastructure has been expanded to achieve greater coverage including rehabilitation and upgrading of some existing facilities, in-service training of staff has been implemented to improve clinical capabilities, extensive capacity development has been instituted to improve system management and efficiency at both central and district level, and improved capability has been built in the Ministry of Health for policy formulation, planning, budgeting and monitoring of the sector.

The government owns and operates a tiered structure of 242 lower level units, 59 hospitals of which 2 are national referral hospitals, 10 are regional referral hospitals, 45 are district hospitals, and 4 are military and police hospitals.[1] The government also provides non-facility based services through national programmes such as Community and Environmental Health and Communicable Diseases Control.

However, despite considerable achievements over the last 15 years there are still significant gaps in access to services and quality of care, particularly in rural areas. Although government funding to the sector is increasing annually, there are still many under-funded and un-funded priorities, and many challenges remain to be addressed to achieve the objectives set out in the HSSIP.

1.2 The Private Health Sector

The Private Health Sector in Uganda is varied and diverse. The following categorisation has been agreed upon during discussions with the various stakeholders in Uganda in the articulation of the PPPH policy.

- Private Not For Profit health providers (PNFP)
- Private Health Practitioners (PHP)
- Traditional and Complimentary Medicine Practitioners (TCMP)
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[1] Health Services Inventory, 2006

1.2.1 Private Not-for-Profit health providers

This category of providers is guided by concern for the welfare of the population. The PNFP includes agencies that provide health services to the population from established static health units/facilities and those that work with communities and other counterparts to provide non-facility-based health services and technical assistance.

a) Facility-Based PNFP

FB-PNFP providers have a large infrastructure base comprising a network of hospitals and health centres. They currently operate nearly 30% of the Health Care facilities in Uganda with a considerable percentage of these units located in rural areas.[2] Many of these PNFP facilities provide health services as well as train health workers. About 75% of the PNFP facilities are represented by four Medical Bureaux, while the rest fall under other humanitarian and community based health care organizations.

b) Non-facility-based PNFP

NFB-PNFP organisations include Civil Society Organizations which may not directly operate through health facilities, but which support or undertake health development activities in partnership with central and local government, with facility-based and other PNFP health providers, with private practitioners, and with communities. Diversity within this category of providers exists by a large combination of characteristics including size, means of and access to finance, control, and motivation.

1.2.2 Private Health Practitioners

The private for-profit health sector encompasses all cadres of health professionals in the Clinical, Dental, Diagnostics, Medical, Midwifery, Nursing, Pharmacy and Public Health categories who provide private health services outside the PNFP establishment. The PHPs have a large urban and peri-urban presence and provide a wide range of services, mainly in primary and secondary care. Few PHPs provide tertiary level services. Curative services are widely offered while preventive services are more limited, with the exception of family planning offered by three-quarters of PHP facilities

[2] Health Facilities Inventory MoH, 2010

1.2.3 Traditional and Complementary Medicine Practitioners

A significant proportion of the population often seeks the services of traditional medical practitioners in addition to or instead of the modern sector of the health service system. Traditional medicine practitioners include all types of traditional healers including herbalists, traditional bone-setters, traditional birth attendants, hydrotherapists, and traditional dentists, among others. The sector does not recognise or embrace people who engage in harmful practices such as casting of spells and child sacrifice.[3] There are several associations with registered members at the sub-county and district levels, coordinated by District Cultural Officers. Many, though, remain unaffiliated to any association. More recently, a number of non-indigenous traditional or "complementary" medical practices have been introduced into the country. Complementary medicine is provisionally defined as the art of using natural, physical or psychic means or products to cure or modify disease or promote health through mechanisms different from standard western type medicine. Current complementary medicine providers in Uganda include practitioners of Chinese and Ayurvedic medicine, chiropractic medicine, homeopathy and reflexology.

1.2.4 In addition to the above recognized categories of PNFP, private, and traditional and complementary medicine practitioners, a number of individuals, often without formal health training, are also engaged in treatment of patients and illegal sale of drugs. These informal providers cannot be considered part of the legitimate private sector unless they regularise and register themselves under one of the recognised categories of private sector providers described above (PNFP, PFP, TCM), and comply with the laws, regulations and standards that apply to their practices.

2. THE HEALTH CARE SYSTEM

2.1 The National Health Policy and Health Sector Strategic and Investment Plan

The National Health Policy and the Health Sector Strategic and Investment Plan provide policy direction for the entire Health Sector in Uganda. The principles behind the NHP and HSSIP are:

- Universal access to a minimum package of health services

[3] More guidance shall be derived from the Legislation on Traditional and Complementary Medicine in Uganda

- Equitable distribution of health services
- Effective and efficient use of health resources
- Promotion of sustainable health financing mechanisms

The NHP II° clearly indicates the policy objective and strategy to build and utilise the full potential of the public private partnership in Uganda (Section 6.7). The HSSIP guides the participation of all stakeholders in health development in Uganda. To achieve its goal, the HSSIP aims to:

- Improve access of the population to the Uganda National Minimum Health Care Package (UNMHCP), with special attention on increasing effective access for the poor and vulnerable groups of the population,
- Improve the quality of delivery of the package and of all health services

2.2 The Uganda National Minimum Health Care Package

The UNMHCP comprises interventions that address the major causes of the burden of disease and is the cardinal reference in determining the allocation of public funds and other health inputs. The Government aims to ensure provision of the UNMHCP to all its population in partnership with other stakeholders in health.

2.3 Levels of service delivery

The health care system has undergone re-organisation and restructuring to improve performance at all levels. This includes central level, district level, and HSD level as detailed in the HSSIP. The different levels of service delivery are centred around services offered at and by VHTs at community level, HC IIs at parish level, HC IIIs at sub-county level, HC IVs at Health Sub-District (HSD) level, district hospitals, regional referral hospitals and national referral hospitals.

At the district level, the functional management unit for health care delivery is the HSD at which planning, implementation, monitoring and supervision of all basic health services within the HSD takes place. The HSD is based at an existing hospital or Health Centre IV (government or PNFP). District, HSD, hospital and health centre personnel at the various levels are responsible for providing a range of facility-based and community-based curative, preventive and promotive public health services set out in the UNMHCP.

At the community level, public and private providers mobilise and empower communities to participate in health development and take responsibility for their own health. The Parish Development Committee (PDC), the Village Health Team (VHT) and recognised Community Resource Persons (CORPs) provide the main entry points to the community, although PDCs and VHTs are not yet established in all areas of the country.

2.4 Role of the Partners

2.4.1 The Role of Government in Health Care

The government is responsible for shaping the National Health System and for the overall health sector development defining roles and responsibilities to be shared among Central Government, Local Government, and Private Partners.

a) ***The role of Central Government***

- Policy formulation, standards setting and quality assurance
- Strategic planning and research
- Regulation of health care providers (public and private)
- Validation and accreditation of regulations and bylaws
- Resource mobilisation
- Capacity development and technical support
- Provision of nationally coordinated services e.g. epidemic control
- Coordination of health services
- Capacity building through training and supervision
- Monitoring and evaluation of the overall sector performance

b) ***The role of Local Government***

- Implementation of national health policies and contribution to policy development
- Planning and management of district health services
- Enactment of regulations and bylaws
- Provision of disease prevention, health promotion, curative and rehabilitative services with emphasis on the UNMHCP and other national priorities

- Vector control
- Health education and promotion
- Ensuring provision of safe water and environment sanitation
- Health data collection, management, interpretation, dissemination and utilization
- Coordination of all health providers (public and private) at the district level
- Monitoring and evaluation
- Resource mobilization

2.4.2 The Role of the Private Health Sector

- Providing priority services to the communities within which they operate
- Contributing towards policies development, planning, monitoring and evaluation
- Resource mobilisation for health care from households, organisations both local and international
- Providing or participating in research, community and social mobilisation, advocacy, capacity building including human resources development, logistical support, technical assistance and other services at all levels
- Ensuring proper utilisation of resources and accountability

2.5 Resources for Health Care

2.5.1 Financing Health Care

Health care financing is complex and the financial flows from sources of health care funds to where health services are delivered are dynamic. The sources of health financing are:

- ***Public*** – funds coming from central and local government, including funds from HDPs channelled through central and local government budget support mechanisms, and through project mechanisms.
- ***Private*** – funds coming from private or non-government sources, including out-of-pocket payments for health services, insurance/prepayment scheme premiums, donations, and projects and programmes funded and implemented by and through NGOs.

However, public health providers are not entirely funded by public sources and often receive a mix of public and private funding. At the same time private providers, which are funded mainly by private sources, in some cases receive and utilise public funds. The

partnership between public and private health providers can together mobilise additional resources to improve the health of the population. The total per capita expenditure on health in Uganda is estimated at about US$ 20 with approximately US$ 10.4 contributed by government and development partners, the rest is from private sources. The present level of funding is inadequate to cover the estimated per capita cost of US$ 41.2 to deliver the MHCP.[4]

The table illustrates the current mix of health services provision and sources of financing, and highlights the areas where public-private collaboration supports achievement of HSSP goals and objective

Service Sectors	*Sources of Funding and Support* **Public Funding Sources**	**Private Funding Sources**
Public Services Government health centres, hospitals, and community health workers	- *Government of Uganda* (central and local government through taxation) - *Development Partners* • Central Budget Support • District Budget Support • Multilateral and bilateral projects and programmes channelled through central or local government	• Private wings • NGO-supported projects and programmes
Private Services • Facility-based PNFPs • Non-facility-based PNFPs • Private Health Practitioners • Traditional and Complementary Medicine Practitioners	• Government subsidies or cost support to private facilities, including infrastructure development • Contractual arrangements with private providers • Participation in government-funded programs • Multi-lateral and bilateral projects and program channelled through central or local government	• Household (user fees) • Insurance (employer-based, community-based, national based and private) • Donations (internal and external) • Income generating activities • Fundraising • Commercial marketing strategies • NGO-supported projects and programmes

Public health services historically have been funded through taxation as well as donor funds, with services provided free of charge to the population. This policy was difficult to sustain in light of the decreasing public funding to the health sector as result of economic decline of the 1970's and 1980's. During this time informal charges were levied in public

[4] Annual Health Sector Performance Report 2008/09. Ministry of Health Kampala, 2009.

health units. In a bid to relieve funding constraints by seeking additional sources of revenue, a formal user charge was introduced at all government facilities in the early 1990's. The government's user fees policy was reviewed in 2000, and user fees at government facilities were abolished in March 2001, except in private wings of government hospitals, in the interest of ensuring equity and access to health services.

FB-PNFPs are financed by external and internal donations, income generating projects user charges, and government subsidies. The resources mobilized for the FB-PNFP sector amounted to UgShs 92 billion for the FY 2008-09, a slight increase of 5% as compared to the previous year. Government contribution amounted to approximately UgShs 17.4 billion which represents 6% of the total national MoH budget and about 16% of the total PNFP expenditures in the past few years.[5] The increase in government subsidies, during the years 2000-2004, although not adequate to meet the entire cost of service provision, has resulted in a consequent reduction of user fees at PNFP facilities.

NFB-PNFPs are funded from a variety of sources such as bilateral and multilateral development partners, private donations and fund-raisings. Government financial support to NFB-PNFPs is at present limited and generally ad hoc in nature, depending on individual agreements.

Households and/or private medical insurance finance services provided by PHP, although a number of private providers also benefit from government and NGO-funded programs and projects particularly in rural areas (training, basic equipment, etc). Primarily the households fund TCMP, through out of pocket expenditure and payment in kind, although a number of TCMP, TBAs in particular, also benefit from government and NGO-funded programs and projects (training, basic equipment, etc).

Health insurance is growing as a form of health financing, although its actual contribution to overall health sector financing is minimal. By sharing the cost of health care, insurance schemes recover a substantially higher proportion of costs that user fees. Employer-based insurance, community based health insurance (prepayment schemes) and private health insurance schemes are operating in Uganda. A National Health Insurance Scheme is ready to be approved.

[5] Annual Health Sector Performance Report 2008/09. Ministry of Health Kampala, 2009

2.5.2 Human Resources for Health

As early as the 1920's, the colonial government and the religious-based clinicians joined forces in the training of medical personnel with the establishment of a midwifery school at Mengo in 1919 and the medical school at Mulago in 1924. Since then there has been continued involvement of the private sector in health training. The government trains most of the human resources for health, with 28 out of a total of 48 health training schools, including schools for laboratory technicians and clinical assistants, while PNFP organisations own and operate the majority of the health training schools for nurses and midwives (20 out of 32). There are also a few private commercially operated health training schools. Government and HDPs support PNFP Health Training Institutions through a bursary scheme (MoU) with the aim to improve the staffing level in public and PNFP health facilities in underserved areas of the Country. The mandate for national education policies and coordination of pre-service training programmes is now with the Ministry of Education and Sports.

Despite some considerable progress over the past ten years, however, trained health workers are still both inadequate in numbers and inappropriately distributed within and between sectors. While more than 80% of the population is found in the rural areas, the distribution of trained health workers favours the urban areas. The PNFP sub-sector currently employs approximately 34% of the facility-based heath workers in the country, while it operates 40% of all hospitals and 20% of all lower-level health centres. In spite of employing less staff than the public sector, attrition of qualified staff from PNFPs to public facilities and private practice continues to be a problem, increasing the unbalance between sub-sectors. The human resource inputs of the NFB-PNFP sub-sector include capacity building, in service training, community empowerment and community-based service delivery. However to date these inputs have not been well quantified.

The human resource contribution of the TCMP sub-sector is also not clearly quantified and requires more research. A recent WHO report, however, estimates that the ratio of traditional medicine practitioners to population in Uganda is between 1:200 and 1:400 compared with a doctor to population ratio of 1:18,000, which implies a potentially significant contribution of this sub-sector to human resources for health services.[6]

[6] WHO Traditional Medicine Strategy, 2002-2005

2.5.3 Technical assistance

Technical assistance and support to national and regional hospitals, district and HSD management teams, and lower-level health facilities, including PNFP facilities, is provided through support supervision mechanisms set out in the National Supervision Guidelines. FB-PNFP organisations provide additional technical assistance for their facilities through their own supervision structures. MoH, HDPs and PNFPs provide additional resources and skilled manpower within the health sector aimed at improving efficiency in planning and management of public systems and building capacity for sustainability.

3. POLICY DEVELOPMENT CONTEXT

3.1 Vision of the partnership

Universal access to affordable health care for all the population of Uganda through an efficiently integrated public-private partnership in health

3.2 Goal of the Partnership

The overall goal for the Public-Private Partnership in Health is to contribute to strengthening the national health system with the capabilities and full participation of the private health sector to maximise attainment of the national health goals.

3.3 General Objectives of the Partnership

- To establish a clear institutional and legal framework to effectively build and utilise the full potential of the public private partnership in Uganda's national health development
- To establish a functional integration and to support the sustained operation of a pluralistic health care delivery system by optimising the equitable use of available resources.
- To invest in comparative advantages of the partners in order to sustain scope, quality, and volume of services to the population

3.4 Rationale for the Partnership with the private sector

On-going reforms in the health sector seek to improve equity, access, efficiency, quality and sustainability of health care. This requires capacity building and resources. Developing strong and supportive partnerships with private health sector organisations and providers will accelerate the attainment of these objectives.

3.4.1 Capacity Building

While significant progress has been made in building district capacity for management of decentralised roles and responsibilities over the past years, there is still a considerable need to continue capacity-building efforts at district, health sub-district, and lower levels to ensure effective and efficient delivery of quality health services throughout the country. Private providers and organisations play a key role in building capacity at different levels of the health system by:

- Supporting the efforts of the MoH to fully and effectively address critical capacity building needs.
- Supporting and coordinating with district and HSD management teams in line with decentralisation policies and arrangements.
- Supporting and working with districts to effectively reach the community level with essential health services.

3.4.2 Equity

Equity is cross-cutting and involves issues of access, quality, and financing, especially for the most vulnerable groups of the population. Subsiding and supporting provision of the UNMHCP through private sector providers increases the proportion of the population that can access quality services.

3.4.3 Access

Guaranteeing equitable access to quality services involves ensuring geographical access and adequate human resources and infrastructure as well as addressing economic, social, cultural, and gender issues that create barriers to accessing services. PNFP health providers are committed to providing services to the most in need populations where public services may not reach. PNFPs also strive to reduce or eliminate barriers to access through subsidised health care schemes at PNFP facilities as well as empowering communities to

recognise and address the social, cultural and gender issues that limit access for marginalized segments of the population. Private Health Practitioners and Traditional and Complementary Medicine Practitioners contribute to increased access by providing services that meet the needs and demands of consumers not catered for by public and PNFP providers.

3.4.4 Efficiency

Government and private sector partners will coordinate and rationalise public and private sector programs and inputs to ensure maximum benefit from all available resources. Private health sector inputs to service delivery systems and structures represent a cost savings to the public sector. The public-private partnership considers to complement service delivery and minimises duplication of services where possible.

3.4.5 Quality

Private sector providers will strive to offer quality services following the minimum quality standards set by the MoH and the UNMHCP. To this aim the establishment of a reliable registration and accreditation system, within each sub-sector, is encouraged. Private sector programs will continue to make significant contributions to infrastructure and human resource development, in both the public and private health sectors, aimed at improving the delivery of quality services at all levels.

3.4.6 Sustainability

Private sector providers contribute to sustainability by maintaining complementary networks of facilities and services that can withstand social, political and economic shocks that may adversely affect the public sector. By working in partnership with government, the mixed system of public and private services thus created is stronger and can compensate for short-comings in either provider. The private sector health infrastructure represents a valuable national asset that needs to be preserved.

3.5 Guiding Principles of the Partnership

The scope and level of the partnership depends on the extent to which partners' missions coincide and to the mutual respect declared to each others.

3.5.1 Responsibility for policy formulation and planning

Overall responsibility for health policy formulation and for the health status of the population is maintained by central government who will consult and aim at consensus with the partners in all cases of common concern. Effective representation of the private sector in the appropriate fora at different levels constitute a precondition for consensus building

3.5.2 Regulation and representation

To contribute to the partnership, the private sector needs to regulate its providers and establish proper structures of representation, at central and district level. The consultation process, between Government and private sector partners, shall be conducted through the representative structures of the partnership and only accredited structures of each sub-sector can contribute to the partnership.

3.5.3 Integration of plans and operations

Plans and operations of the private health sector shall support the HSSIP and must be integrated into district health plans. The planning process shall encourage participation of private sector representatives at their respective level of service delivery.

3.5.4 Responsibility for service provision

The Decentralisation Policy, the NHP II, the HSSIP, and MoH Guidelines for Provision of the UNMHCP guide responsibility for provision of health services to the population at different service delivery levels.

3.5.5 Complementarity

Government and private sector partners shall strive to rationalise and complement services rather than duplicating them.

3.5.6 Identity and autonomy

The identity and autonomy of each partner shall be accepted and respected.

3.5.7 Equity

Government and private sector partners will ensure the equitable allocation of resources for health in accordance with the needs of the population. The partnership aims at providing care to the poorest and most disadvantaged people, reducing economic barriers which prevent access to health services for the most in need population.

3.5.8 Quality and Efficiency

Service provision by public and private providers shall focus on quality and efficiency to attain maximum benefits. The element of quality is emphasized on actions and items used in providing health services according to the standards defined by the Government.

3.5.9 Transparency and accountability

Inputs, outputs and outcomes relating to achievement of HSSIP goals and objectives shall be agreed, reported by and shared among the partners. Partners are responsible for accounting and reporting within their organizational structures, to central and local government, and to community.

3.5.10 Sustainability and Continuity of Care

Sustainability of service provision to the population shall be central to the partnership for the purpose of continuity of care. Infrastructures, financial and human resources available by the sectors shall be utilized in an efficient and coordinated way to maintain the scope and extent of the health services to the population. Continuity of care shall entail that referrals between public and private facilities are ensured.

4. PARTNERSHIP IMPLEMENTATION

4.1 Priority Areas of Partnership with the private sector

The implementation of the partnership will be guided by the principles in this policy. To make the best use of each other's comparative advantage, mission and effectiveness the following priority areas of partnership will be developed into implementation strategies by each sub-sector.

4.1.2 Policy development, HSSP monitoring and evaluation

Health policy dialogue between Government of Uganda and stakeholders in the health sector will take place in the Health Policy Advisory Committee (HPAC), the Advisory Board on Health and the National Health Assembly.[7] These fora will include representatives of the different health care partners. All health providers will be involved in sector performance review at the different levels (central and local). At the central level the representatives of the different providers will participate in HPAC, the Working Group on PPPH, the Joint Review Missions, and the National Health Assembly.

4.1.3 Co-ordination and planning

Co-ordination and planning for health services takes place at both central and local government levels. The appropriate level of government will take responsibility for co-ordinating and regulating the different providers as well as for overall joint planning for health services within their area of jurisdiction. The District Health Management Team will take the lead at district level, while the Desk Office, within the Directorate of Planning and Development MoH, will take the lead at the central level. The relevant bodies will include representatives of the private partners.

4.1.4 Financial resource mobilisation and allocation

Resource mobilisation for health service provision is a core responsibility of the government. Private health providers will contribute by mobilising additional resources for sustainable health financing. The allocation and utilisation of public health resources shall be guided by the objectives of the National Development Plan. Allocation of resources for health will be made according to the volume and quality of the contribution to the implementation of the HSSIP taking into account the health care needs of the population. The budget process at the central level (MoFPED and MoH) and at local government levels will be participatory. Private sector partners will share information about relevant financial inputs and expenditures with the appropriate authorities and other stakeholders.

4.1.5 Human resource for health management

Partnership for human resources development and management requires participatory development of the strategies and plans for training of health workers in order to meet the

[7] The National Health Policy, 1999 (section 7.2 f)

human resource needs of the sector. Equitable opportunities shall be granted to public and private staff for in-service training. PNFP and private training institutions will receive support from the Government as needed to help meet essential human resource needs within the sector and within the Country.

4.1.6 Capacity building/management

Strong institutions with good management practices are essential for successful health programmes. This calls for financial and technical assistance. Private sector partners can provide valuable inputs especially to districts and CSOs to develop the required capacities and effectively take on health care roles under the decentralisation process and SWAp.

4.1.7 Community empowerment and involvement

Government resources alone are not sufficient to enable the health care system to meet demands and ensure sustainable access. Effective community participation and involvement in financing, planning, implementation and managing programmes is therefore a critical requirement. Owing to their flexibility and grassroots programme focus, the role of the private sector partners is to mobilise communities, demand accountability, and impart skills that will empower them to access their rights to services and to fulfil their role in managing and supporting these services.

4.1.8 Service delivery

District authorities are empowered to delegate the responsibility for provision and management of health services to the private sector as appropriate, guided by the HSSP and the HSD concept. The ethical principles of the partners will be respected and they will be granted the freedom not to implement health activities that are in conflict with their principles.

4.2 Institutionalising the Partnership

4.2.1 Structures of the partnership

The structure of the partnership is dictated by the decentralised health system. The different sub-sectors in the private health sector will be structured and organised both at central and local government levels. The existing institutional mechanisms shall enable the participation in the partnership as appropriate in line with the policy of decentralization. At the same time, structures, which are not currently operating shall be made operative. At all

levels where partnership issues are being discussed, the partners shall always ensure adequate representation. The Government shall acknowledge the mandate of the representative. The following are the key *fora* of consultation

4.2.1.1 Central level

The principal partners at central level are the Ministry of Health, the Ministry of Local Government, the Ministry of Finance Planning and Economic Development, the Ministry of Education and Sport, the Ministry of Public Service, Health Development Partners and designated representatives of the private sector. These partners will represent the highest authority in the partnership for policy and guideline development including refinement of the policies and guidelines on the basis of the monitoring and evaluation outcomes. The joint structures at this level are:

a) Joint Review Mission

Role: To review financial, technical and institutional progress in the sector and agree on the outputs and resources allocated for the upcoming financial year.

b) Health Policy Advisory Committee (HPAC)

Role: To discuss health policy and to advise on the implementation of HSSIP. HPAC works through the established MoH structures and systems

c) Working Group on PPPH

Role: To facilitate dialogue between Government and private health sector Partners in preparation of guidelines and policy proposals, and to facilitate co-ordination with the Ministries

d) Sub-Working Groups (PNFP, PHP, TCMP).

Role: To facilitate dialogue between Government and each private sub-sector in development and implementation of policy proposal and guidelines.

To coordinate and represent each sub-sector

To advocate and facilitate the Partnership at different levels

e) MoH/PPPH Desk

Role: To advocate and facilitate partnership at different levels

To liaise with private sector partners, collect and disseminate information

To facilitate operations research into specific PPPH issues

To act as a secretariat of the PPPH working group and sub-working groups

f) Umbrella Organizations (PNFP, PHP, TCMP).

Role: To represent their members and promote partnership initiatives

To coordinate the different health providers from each sub-sector and promote professional development and ethics

To provide support services and accredit the member facilities and providers

g) Interministerial Standing Co-ordinating Committee (MoES-MoH) for training health workers.

Role: To set the priorities, co-ordinate the stakeholders, monitor progress and refine the policy and strategic HR development plan.

4.2.1.2 Local Government Level

The main functions at this level relate to implementation. The primary structure for coordination and functional integration is the District Health Management Team .

a) The District Health Management Team

Role: To prepare annual plans, propose allocation of resources within the district, provide technical assistance to the health facilities, inform, consult and co-ordinate other district stakeholders, monitor and evaluate progress, propose improvements.

Owing to the needs of the partnership, two new structures at the district level shall be required to facilitate co-ordination:

b) The District PPPH Desk Officer

Role: To facilitate information flow between district authorities and private sector representatives, facilitate understanding and harmonisation of implementation arrangements. The assignment will be made by the DDHS from within the existing DHMT, in consultation with the coordination committees.

c) The Co-ordination committees (PNFP, PHP, TCMP)

Role: To represent the sub-sectors' facilities, providers, and programs of different ownership existing at district level

To coordinate facilities, providers, and programs from each sub-sector

To mobilize and coordinate resources flow between district and private sector partners.

To harmonise approaches, define the common issues, propose solutions, and ensure information exchange.

Other key structures at the district level:

d) The Health Sub-District Management Committee

Role: To prepare plans and assist the health facilities and community groups to deliver the UNMHCP within the HSD.

To inform, consult and co-ordinate other sub-district stakeholders, monitor and evaluate progress, and propose improvements.

e) Hospital Board

Role: To advise and supervise hospital management on key operational issues including finance and human resources.

To ensure accountability to the community, to the health authorities, and to the owners.

f) Health Unit Management Committee

Role: To direct and supervise implementation and quality of UNMHCP services

To monitor and evaluate progress

To supervise management of the health facility

To liaise between management, community, and stakeholders.

g) Sub-county Health Committee

Role: To prepare plans, reports and budgets to be presented to the Sub-County Council (LC3) and to the HSD management team.

h) Parish Development Committee (for PNFP facilities and faith based CSOs)

Role: To collect and analyse data, identify the community's health needs, and prioritise and take appropriate measures. Where such committees exist, the PNFP facility and CSOs

partners can provide technical assistance and support to train PDC members, to assist in data analysis and generally advise the PDC during its deliberations.

i) Village Health Team

Role: To identify the community's health needs and priorities and develop plans to take appropriate measures,

To mobilize additional resources and monitor use of all resources for their health programmes including performance of health centres

To mobilise communities, maintain registers of households and their health status and serve as the primary link between the community and health service providers.

4.2.2 Strategies for institutionalising the partnership

Functional integration of autonomous partners will be built into the institutional framework of each partner to ensure continuous structural dialogue and co-ordination. The existing institutional mechanisms will be adapted to allow participation of the private sector.

4.2.2.1 Development of an integrated health care system

The operational integration of the private sector facilities, providers, and programs at their respective functional level shall be guided by the demands of the decentralised setting, the commitment to safeguard the identity of each partner, and the decision to delegate public service roles and responsibilities to the Partners.

The operation of the structures of the partnership at different levels shall aim at:

- Consistency in gathering and reporting information
- Consensus decision-making on policies, strategies and implementation
- Co-ordination and accountability in service delivery
- Joint planning, monitoring, and evaluation of the HSSIP implementation.

4.2.2.2 Formalisation of responsibilities and arrangements

Formalisation of the delegated responsibilities and working arrangements will ensure commitment and accountability and thus strengthen the partnership relationships and their institutionalisation. In line with the division of responsibilities between central and district government, the formalisation shall involve the three levels:

- At central level the basic principles and mechanisms shall be agreed, between Government and representative of each private Sub-Sector, and formally stated in Memoranda of Understanding
- At district level, the national MoU will be adapted to local policies and priorities. Contracts and agreements shall be defined between district authorities and representatives of the private Partners.
- At the facility level formalisation shall be sought according to the context and appropriate option.

4.3 Tools of the partnership

4.3.1 Existing legislation and regulations

When revising health legislation and regulation, the objectives and principles of partnerships will be taken into account in view of strengthening the relationship and facilitating implementation.

4.3.2 Formalisation of the arrangements.

Formalisation of the partnership is determined by national legislation, regulation and administration systems as well as specific health care legislation, regulation and administrative systems. There are two options to formalise partnership arrangements, which can be applied as appropriate:

a) The general administrative approach

The assignment of functions, allocation of resources, reporting and accounting shall be agreed according to the profile of the health providers. Obligations and agreed arrangements shall be integrated into existing administrative systems at central and district level.

b) The contractual approach

The capacity of the Partners to develop, negotiate, implement and control contracts is a prerequisite. The contractual approach shall be developed in a consultative, planned and phased manner.

4.3.3 Memoranda of Understanding

Memoranda of Understanding, at central and local government level, shall set out the intentions, policies, principles, and fundamental mechanisms agreed on governing their collaboration. The MoU will function as important tools to:

- Institutionalise the relationships with the private sector partners and implement the working arrangements in the different phases and at the various levels
- Provide guidance and direction for agreements and contracts at lower local levels
- Provide terms of reference for monitoring and evaluating progress at each level as well as for accounting for the contributions and inputs of each partner
- Enable internal and external parties to play their role in ensuring transparency.

4.3.4 Agreements and Contracts

Agreements and contracts specify what each partner shall do to contribute towards agreed objectives set by the HSSIP. These mechanisms will:

- Develop and strengthen the partnership at implementation level
- Ensure mutual responsibility
- Formalise commitments and agreed intermediate objectives
- Improve internal and external accountability and transparency.

4.3.5 Accreditation of private facilities

The development of an accreditation system facilitates regulation of each sub-sector by the respective Umbrella Organizations, Professional Councils, and other relevant regulatory bodies. The accreditation system shall set out the requirements for each level of health service delivery according to government standards. Accreditation shall be based on criteria of excellence, in line with the NHP and HSSIP, and will be applied to all aspects of service delivery, including management and accountability. Procedures will be applied to verify and enforce compliance, including self-regulation.

4.3.5.1 Recommended criteria for accreditation of FB-PNFP sub-sector include:

- The PNFP facilities shall be accredited to operate by respective Medical Bureaux
- The facility shall operate on a not-for profit basis and within the mission and policies set by their respective Umbrella Organisations.

- The facility shall be licensed to operate by the Uganda Medical and Dental Practitioners Council
- The facility will provide and maintain premises adequate to the expected service delivery
- The facility will be staffed with qualified personnel and basic equipment in line with current MoH standards, policies and protocols

4.3.5.2 Recommended criteria for accreditation of facilities of the PHP sub-sector include:

- The PHP facilities shall be accredited to operate by respective Umbrella Organizations
- The facility shall operate within the mission and policies set by Umbrella Organizations.
- The facility shall be licensed to operate by the Uganda Medical and Dental Practitioners Council.
- PHPs shall be registered and licensed with their respective Professional Councils according to prevailing laws and regulations.
- The facility shall provide and maintain premises adequate to the expected service delivery
- The facility shall be staffed with qualified personnel and appropriate equipment

4.3.5.3 Recommended criteria for accreditation of TCMP sub-sector include:

- The TCMP facilities shall be accredited to operate by respective competent Umbrella Organizations.
- The facility shall operate within the mission and policies set by Umbrella Organizations.
- The facility shall be licensed to operate by the Uganda Medical and Dental Practitioners Council or other recognized institutions.
- The facility shall provide and maintain premises adequate to the expected service delivery
- The facility shall be staffed with qualified personnel and appropriate equipment.

- TCMP shall be registered with their respective Regulatory Bodies, according to the laws and regulation which will be defined.

4.3.6 Registration of NGOs and CSOs

CSOs partners shall be registered with the appropriate authorities at central and/or district level according to current laws and regulations.

4.3.9 Health Management Information Systems

Timely sharing of reliable information among partners is important for planning, resources allocation, and accountability. All partners will contribute to collect information at all levels utilising the HMIS and other information systems compatible with the HIMS. All partners submitting data to the district and HSD shall receive timely feedback.

4.4 Mediation and arbitration of disputes

Whenever a dispute arises between the stakeholders an amicable settlement shall be sought through the following structures at local government level, depending on the nature of the controversy:

- District PNFP Co-ordination Committee
- District PPPH Desk Officer
- DHMT
- District Health Committee
- District Council

In case the dispute is not settled at the level of local government it shall be handled at central level by the following structures:

- MoH/PPPH Desk Office
- PPPH Technical Working Group and Sub-Working Groups
- HPAC
- Senior Management Committee/MoH

Part Two

Policy Framework for Partnership with

Private Not-For-Profit Health Providers

PART TWO

POLICY FRAMEWORK FOR PRIVATE NOT-FOR-PROFIT HEALTH PROVIDERS

The purpose of Part Two is to provide a framework for institutionalising and guiding the implementation of a partnership between government and the private not-for-profit health service providers, both FB-PNFP and NFB-PNFP, and to create an enabling environment for participation in health development.

5. SITUATION ANALYSIS

5.1 Definition

The Private not-for-profit health providers include organisations/institutions providing health services and having the following characteristics:

- Private organizations operating under the guidance of a written charter
- Do not distribute surplus to their owners or directors
- self governing organizations equipped with structures to control their own activities
- Have paid staff employed by the organization
- Have some meaningful voluntary component such as voluntary labour, donations, and provisions for subsidy of fees

PNFP providers comprise a wide range of organisations that can be categorised as facility-based and non-facility-based. Nevertheless, a number of organisations support or undertake a combination of activities, which are both facility-based and not-facility-based.

5.1.1 Facility-based private not-for-profit health providers

The FB-PNFP providers have a substantial capital/infrastructure investment in static health units (facilities). They have a large infrastructure base which includes a network of hospitals and health centres accounting for 46 of the 113 hospitals, and 20% of the 3124

lower level units in the country[8] with a considerable percentage of these units located in rural areas. In addition, the FB-PNFP operates 20 health training schools, out of the 48 in the country. The majority of the FB-PNFP are religious-based health care providers existing under four umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Muslim Medical Bureau (UMMB), and the Uganda Orthodox Medical Bureau (UOMB). [9] Together these Bureaux represent 75% of the 659 PNFP health units, while the remainder fall under other humanitarian organisations and community-based health care organisations.

5.1.3 Non-facility-based private not-for-profit health providers

Non-facility based (NFB) PNFP organisations include international, national and local NGOs and CSOs. NFB-PNFPs may not directly own and operate service delivery facilities themselves, but support or undertake health development activities in partnership with central and local government, facility-based and other PNFP providers, private practitioners, and communities. Their contribution is generally in areas ranging from social awareness and advocacy to more specific aspects of non-facility-based service delivery, diseases prevention and control at community level. Their area of emphasis tends to conform to agency expertise such as special disease programmes, technical assistance, training, capacity building, emergency and relief services, and mainstream service delivery with facility-based partners.

a) International NFB-PNFP organisations

International NFB-PNFP health providers are those that have home offices or headquarters outside of Uganda. Some of them have established a presence in Uganda with the intention of undertaking a variety of longer-term development programs or projects over an indefinite period of time. Others are implementing or undertaking specific and time-bound health development programs, projects or assignments in the country. Some of them may be also affiliated to international organisations.

[8] Health Services Inventory 2006 (excludes Private Health Practitioners facilities)
[9] List of allocation of PHC CG non –wage Recurrent (2005/06 and 2006/07)to PNFP facilities

b) National NFB-PNFP organisations

National NFB-PNFP have head offices or headquarters within Uganda and operate only within Uganda. These organisations implement or undertake activities at central level with national-level partners, may have programs throughout the country or in a significant number of districts. They include national umbrella organisations, which represent smaller or lower-level organisations, and national faith-based organisations as well as autonomous organisations.

c) Local NFB-PNFP organisations

Local NFB-PNFP (local NGOs and CSOs) are organisations that operate within a limited geographic area at district level or below, and establish partnership or operating agreements with district authorities rather than with the MoH. Their representation and interests may be catered for by various national-level umbrella organisations.

5.2 Organisation and structures of co-ordination

5.2.1 FB-PNFP organizations and facilities

The majorities of PNFP facilities are owned by their respective churches/denominations and are part of their institutional framework. As each church/denomination is organized differently these institutions and the organizational settings are not identical but have one aspect in common: the hierarchy does not correspond with the governmental system. The units of the small churches and Muslim organizations fall under the authority of the national church/denominational hierarchy. The units of the RCC and of the CoU fall under the authority of autonomous dioceses. Other faith-based organizations have different hierarchical structures.

The four main religious denominations have established coordinating structures at national level that are known as Medical Bureau. UPMB was established in 1955, UCMB in 1956, and UMMB in 1998, and the UOMB in 2009. The Bureaux main functions are to represent, propose policies, co-ordinate, provide support services, and accredit the member units. They do not have authority over the individual units or owners.

In general terms the religious-based FB-PNFP are well organised and enjoy some degree of supervision by their respective Bureau. Although independent and administratively autonomous organisations, they have a sense of belonging around shared values and organisational cultures that constitute their identity. Facilities belonging to other organisations of humanitarian inspiration have been established in different ways and have less developed structures of co-ordination.

5.2.2 NFB-PNFP organisations

Coordination between NFB-PNFPs and the MoH and between NFB-PNFPs themselves is, at present, poorly organised and generally ad hoc in nature. Individual organisations tend to establish their own relationships with various donors, MoH departments, and co-ordinating bodies depending upon their current involvement in different types of programmes and their level and areas of interest. NGOs operating in the same geographic or technical areas may, or in many cases may not, establish collaborative relationships with one another to coordinate their activities in the field. Some forums of coordination have been developed over the years but with limited capacity to represent the wide and varied range of NFP-PNFP providers due to the diverse nature of the CSOs costituency.

5.3 Mission

PNFP providers, both faith-based and humanitarian, base their involvement in delivery of health services on their commitment to improving the human condition and society. They provide non-profit services, and despite significant differences between them they share a common mission "*To pursue the health and well being of the person and the community, through promotion of equity, solidarity and mutual support*". This mission is in harmony with the mission of the MoH.

5.4 Contribution to the health system

5.4.1 Policy development

The participation of FB-PNFP representatives in the policy and plans formulation has been extensive at central level. Participation in planning at local government level with district partners is more extensive, but still not yet fully institutionalised. It shall be

promoted and strengthened at local government level. Processes of joint monitoring and evaluation have also started at central level and shall be extended at district level.

5.4.2 Health service delivery

a) Planning and Management of Health services

Both NFB- and FB-PNFP organisations offer technical assistance and support for planning and management to District Health Management Teams. FB-PNFP provide services to the population where their units are located, and a number of PNFP health facilities have been appointed Health Sub-District (HSD) headquarters representing about 15% of the total sub-districts. FB-PNFP in charge of HSD are members of the DHMTs and participate in the annual planning exercises.

b) Infrastructure

The FB-PNFP sector presently has 659 health units, 46 of these are hospitals, and 613 lower level units compared with MoH which operates 59 hospitals and 2.242 lower level units. Of the 48 health training schools in the country, 20 are operated by FB-PNFP organisations. The PNFP facilities are largely found in the rural areas (86%)[10]. While the NFP-PNFP organisations do not own health facilities, they contribute to development of infrastructures for health services by providing human, material and financial resources.

c) Uganda National Minimum Health Care Package

The majority of the PNFP hospitals already cater for nearly all components of UNMHCP. The lower level units ensure a significant number of components to variable degrees[11]. The NFB-PNFP programs contribute to virtually all components of the UNMHCP through a variety of initiatives and projects.

d) Emergency and disaster response

Both NFB- and FB-PNFP organisations play a key role in providing emergency and disaster response.

[10] Health Service Inventory 2002 and PPPH Survey 2001 (excludes Private Health Practitioners facilities)
[11] Survey of PNFP Units, PPPH Desk MoH 2001

e) Community - based health services delivery

NFB- and FB-PNFP organisations and programs have historically provided the majority of training and support for community health workers and resource persons, delivery and support for community mobilization, health education, delivery and support for home-based health care and prevention programs, training and support for community-based HUMCs, SCHCs, PDCs, VHTs, and CORPs.

f) Delivery of social services

NFB and FB-PNFP organizations and facilities continue to play a major role in providing social support for communities, for example in water and sanitation, support for people with disabilities, PLWA, families living with HIV/AIDS, orphans, and undertaking programs to mitigate the social and economic impact of diseases and civil strife.

5.4.3 Financing

FB-PNFP organisations contribute to the financing of health services through mobilising resources from abroad, through user fees, and through various local initiatives for income generation. In addition FB-PNFP facilities receive support from government through delegated funds. The total contribution of government of Uganda to the FB-PNFP (PHC Conditional Grant, Drug Credit Line, Lab. Credit Line) has been increasing over the years from Uganda Shillings 3bn in 1998 to Uganda Shillings 19 in FY 2008/09.[12]

In areas where the PNFP are the sole health providers the population may not enjoy the same degree of access to health care as elsewhere because of the user charge levied, though most facilities strive to offer flexible terms of payment and are exploring pre-payment and insurance schemes to help off-set these concerns. FB-PNFP are also undertaking discussions with MoH to offer a range of free services as part of their terms for receiving increased levels of delegated funds.

Although a number of HDPs have now shifted their funding into central budget support and sector-wide approaches and away from direct project funding, NFB-PNFP organisations continue to access a significant level of development funding in the health

[12] Annual Health Sector Performance Report. Fiscal Year 2008/09. MoH, Kampala, Nov. 2009

sector from external sources. Government funding to NFB-PNFPs has, to date, been limited and ad hoc in nature. Concerns are now being raised that as project funding continues to decrease, NFB-PNFPs will lose much of their funding base unless new mechanisms are identified.

5.4.4 Community participation

PNFP providers promote community participation and empowerment at all levels. The majority of FB-PNFP operate their services under the guidance of charters that envisage a variable degree of community participation. Traditional, cultural, religious and gender leadership are criteria for the selection of members in management boards/committees. This has been an important factor of stability. Recent data show that 62% of FB-PNFP are now run by management boards/committees. The majority of NFB-PNFP health programs also emphasise community empowerment and community participation in planning, monitoring, and managing health services at all levels, and have extensive experience and skills in working at community level.

5.4.5 Human resources development

The total number of health workers employed at FB-PNFP facilities is 11.114 as by June 2007[13]. This is up 10% from the 10.000 as of November 2004. Although this is a large workforce, it is far from being adequate. Terms and conditions of employment are not uniform within the sector and differ from those offered by the civil service. Attrition of qualified health staff from PNFP facilities to public service and private practice remains a serious concern.

The human resources of the NFB-PNFP organisations, though not yet quantified, mainly contribute to the area of capacity building, in service training, community empowerment and community-based service delivery. PNFP investments in training of human resources for health are substantial. 20 out of 32 nurses/midwives training schools in the Country belong to the PNFP. Every year the PNFP sub-sector qualifies between 500 and 600 nurses/midwives (over 60 % of the total Country annual output)[14]. The staff trained in FB-PNFP institutions are deployed in Public and Private sectors.

[13] Annual Health Sector Performance Report. Fiscal Year 2008/09. MoH, Kampala, Nov. 2009
[14] MoH HDPs Health Training Bursary Fund for Students In PNFP Health Training Institutions. MoH, Kampala, March 2010

In addition, the sector endeavours to mobilise funds for human resource development. NFB-PNFP organizations provide substantial support to human resources development in terms of personnel, financial and material contributions to public and private training institutions. They also provide significant levels of support for capacity building through training of national and district trainers, and in-service training of health providers in essential clinical and health service management skills. Up-dated national pre- and in-service clinical training curricula and clinical guidelines have been developed, tested and disseminated to districts with support from NFB-PNFP implemented programs.

5.4.6 Technical Assistance

PNFPs provide technical assistance at various level in the health sector:

a) Central Ministry level

NFB- and FB-PNFPs participate actively in technical policy formulation, development of protocols and guidelines, and development of quality standards and systems.

b) Health training institutions NFB- and FB-PNFP organisations and programs provide significant levels of technical assistance for development of training curricula, development of distance-learning materials and systems.

c) District and lower level

A number of NFB-PNFP programmes provide support and work directly with district and HSD management teams to build capacity for effective planning and management of district health services. District-based NFB-PNFP programmes present a key partnership opportunity for MoH to expand its capacity to provide hands-on technical assistance to district and HSD management teams to effectively take on increased responsibilities under decentralisation

5.5 Existing collaboration

Various levels and forms of collaboration have been developed over the years between PNFP health providers, the Government, and other development partners in the health sector:

5.5.1 Facility-Based PNFPs

Collaboration between Government and FB-PNFPs has been ongoing for decades. Although these services have changed somewhat over time, direct service delivery to the people remains the strong point of the FB-PNFP organisations. Recognising the importance of these services, government has found, over time, ways and means to support this function through secondment and posting of personnel, provision of funds and supplies, especially those related to national priority health programs (e.g. EDMP kits, UNEPI vaccines and equipment). Since 1997/98 financial support to FB-PNFP facilities has been increasing and has been channelled through the decentralised structures of Government.

FB-PNFP facilities participate in all major health care programmes. Exchange of information and data has progressively improved. The representatives of FB-PNFP participate in a number of national level consultative forums, and are represented members of the HPAC. With other partners in health they have shared in the process of developing the new National Health Policy and the Health Sector Strategic Plan. The medical Bureaux provide structures for liaison between Government and their affiliated units in the process of information flow/and exchange.

FB-PNFP organizations also collaborate among themselves, with NFB-PNFP providers, with other NGOs, foreign donors, and development partners and with private health care providers in the areas of service delivery, technical assistance, financing, and information exchange among others.

5.5.2 Non-Facility-Based PNFPs

NFB-PNFP organisations have been making significant contributions to the health sector in Uganda for a number of decades. International and, more recently national, NFB-PNFP organisations have historically been the “partner of choice” for donor agencies in implementing priority donor-funded programmes. Capacity, experience and expertise, flexibility accountability, commitment and reliability have been among the chief advantages offered by NFB-PNFPs to donors, government and other development partners. These organisations continue to fill critical gaps in public and private sector services throughout the country. NFB-PNFP have been and continue to be particularly

successful in targeting the most disadvantaged communities and vulnerable segments of the population which government finds hardest to reach.

The majority of NFB-PNFPs have, in recent years, moved progressively into long-term development work in support of emerging national (and global) priorities and objectives. With vastly improved national capacity now in place, many NFB-PNFPs have increasingly shifted their focus away from direct service delivery toward providing technical assistance and capacity building within the public and private sectors, at national, district, and community levels.

In addition to this shift in focus, international NFB-PNFPs increasingly draw on Ugandan expertise to plan and implement programmes together with international expertise. This strategy allows NFB-PNFPs to offer a broad range of capabilities outside of the established government structures which can capture and focus on best practice within Uganda as well as regionally and globally.

6.1 POLICY DEVELOPMENT CONTEXT FOR PARTNERSHIP WITH PNFP

6.1 Rationale

The rationale for establishing a partnership between Government and the PNFPs is supported by the following considerations:

6.1.1 National policies, plans and sector-wide approaches

The NHP and the HSSIP, as well as sector wide approaches, require that the health sector be viewed as a system to which different actors contribute. This means that collaboration and partnership between the different actors must be developed with clearly defined institutional arrangements and processes.

6.1.2 Service delivery orientation

The government and PNFP missions and objectives for the health sector coincide. This translates into a comprehensive approach to provision of health services for the individual

and for the community, with a particular focus on community participation and empowerment.

6.1.3 Improving equitable access to health services

A significant proportion of the population faces geographical and financial barriers to accessing health services. FB-PNFP health facilities significantly increase access to basic UNMHCP health services throughout the country and especially in rural areas, thereby reducing inequities of access between population groups. NFB-PNFPs contribute to increased access to health services by focusing on service delivery at the grassroots level.

6.1.4 Optimising available resources through functional integration

The endowment of infrastructure and equipment, human capital and capacity together with experience accumulated through the years by the PNFPs contributes to the attainment of the national health goals. Functional integration reduces competition and duplication which can result in a waste of resources.

6.1.5 Potential for financial resource mobilisation

PNFP organisations can mobilise significant resources for health through private donations, voluntary work, and income generating activities. All of these constitute additional inputs for the implementation of the HSSIP.

6.1.6 Capacity for developing human resources for health and skills transfer

PNFPs have established over the years the capacity for training of health personnel through support to pre-service institutions and in-service training programs that substantially contributes to the development of human resources needed for the implementation of the HSSIP.

6.1.7 Accreditation of PNFP facilities

The existence of structures of co-ordination within FB-PNFP Bureau, shaped around the principles of their shared Mission and policies, provides a system of accreditation that supports the regulating capacity of Government.

6.2 Specific Objectives of the Partnership with PNFP

- Increasing equitable access to health care by the population, particularly the vulnerable groups, through appropriate interventions and optimal delivery of health services, consistent with the principle of complementarity.
- Optimizing use of available resources through functional integration of public and private health services in the national health system at different levels.
- Improving quality of services through a participatory quality assurance process and integrated Human Resource Development Plan.

6.3 Priority areas and strategies of the Partnership with PNFP

The strategies outlined in the following priority areas of the partnership are guided by the rationale and objectives of the partnership. They are further detailed in the Implementation Guidelines for the PNFP

7.1.1 Policy development, HSSP monitoring and evaluation

The HPAC and Joint Review Mission, the Advisory Board on Health and the National Health Assembly are designated fora, among others, where government, development partners and other stakeholders including representatives of PNFP organisations ensure joint policy development and HSSIP monitoring and evaluation.

Strategies:

- Joint policy development and advocacy
- Joint HSSIP monitoring and evaluation through participation in the quality assurance process at all levels
- Recognition and utilisation of PNFP accreditation system

7.1.2 Co-ordination and planning

To optimize the equitable use of available resources, adequate structures will be in place at the central and local government levels to ensure co-ordination and participatory planning with PNFP partners.

Strategies:

- Joint planning and management
- Establishing coordination structures and mechanisms of consultation
- Developing, undertaking and sharing innovative interventions and best practices

7.1.3 Financial resource allocation and management

Within the partnership, the resources available to the health units and training institutions will be taken into account during the process of the planning and budgeting cycle. At the central level an allocation formula between and within the different levels of the PNFP sub-sector shall be defined in agreement with the partners on the basis of the principle of equity and complementarity. Government subsidies to the PNFP sub-sector shall be distributed on the basis of agreed outputs, in accordance with the priorities of the HSSIP. A framework for accountability will be agreed and adhered to by all partners.

Strategies:

- Sharing information on available resources and participatory budgeting process
- Provide subsidies to the PNFP to achieve agreed outputs
- Developing contractual approaches as appropriate

7.1.4 Human resources development and management

The contribution of the PNFP sub-sector to the development of human resources for health is substantial. Available human resources will be equitably deployed across the health delivery system. The human resource development plan will take into account the training potential of all institutions.

Strategies:

- Harmonisation of staffing norms, salary structures and terms of employment
- Equitable distribution of health staff
- Participation of PNFP training institutions in the preparation and implementation of the Human Resource Development Plan

7.1.5 Capacity building

Strong institutions with good management practices are essential for successful health programmes. This calls for financial and technical assistance. The PNFP are stakeholders that can provide valuable inputs especially to districts and CSOs to develop the required

capacities and effectively take on health care roles under the decentralisation process and SWAp.

Strategies:

- Support to training programs aimed at building management capacity at all levels
- Equal access to initiatives of capacity building and skills development
- Provision of technical assistance and support to build capacity on the job at all levels

7.1.6 Community empowerment

Government resources alone are not sufficient to enable the health care system to meet demands and ensure sustainable access. Effective community participation and involvement in financing, planning, implementation and managing programmes is therefore a critical requirement. Owing to their flexibility and grassroots programme focus, NFB-PNFP partners will be called upon to mobilise communities and impart skills that will empower them to access their rights to services and to fulfil their role in managing and supporting these services.

Strategies:

- Develop and strengthen participatory methods and community structures
- Mobilisation and sensitisation about rights and responsibilities at community level

7.1.7 Service delivery

The integrated district health system sets out roles and responsibilities for partners in service delivery according to the operational levels.

Strategies:

- Preservation of administrative autonomy and identity of PNFPs within the framework of MoH policies and standards for service delivery.
- Delegation of responsibility for service delivery to PNFPs including management of HSD.
- Rationalisation of health services, including appropriate location of new facilities

Part Three

Policy Framework for Partnership with

Private Health Practitioners

PART THREE

POLICY FRAMEWORK FOR PARTNERSHIP WITH PRIVATE HEALTH PRACTITIONERS

The purpose of Part Three is to provide a framework for institutionalizing and guiding the implementation of a partnership between government and the Private Health Practitioners (PHP). The policy, therefore, addresses the partnership between the Ministry of Health, local governments, the PHPs and all other stakeholders participating in health development.

8. SITUATION ANALYSIS

8.1 Definition

The Private Health Practitioners sub-sector encompasses 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. The Medical and Dental Practitioners Statute (1996), the Nurses and Midwives Statute (1996), the Pharmacy and Drug Act (1970) and the Allied Health Professionals Statute (1996), all provide for licensing and regulation of health professionals who wish to engage in private practice, defining the legal status of PHP partners.

In general PHPs provide services demanded by a section of the population that is also willing to pay for such services under different arrangements (out of pocket payments, insurance schemes, etc.). A number of public and PNFP health staff also provide private services. These practitioners are considered part of the PHP sub-sector for their work outside public and PNFP facilities, therefore are covered by this policy.

The PHP are represented by a number of umbrella organizations. The Uganda Private Medical Practitioners Association (UPMPA) represents doctors, while the Uganda Private Midwives Association (UPMA) represents the Midwives. The membership of the other

professional associations is composed of public and private health workers. The Uganda Medical Association (UMA) represents doctors, the Pharmaceutical Society of Uganda (PSU) represents the pharmacists, the Uganda Dental Association (UDA) the dentists, the Uganda Association of Allied Health Professionals (UAAHP), the Uganda Private Health Unit Association (UPHA). Membership to these associations presently is voluntary and not a prerequisite to licensing.

8.2 Organization and structures of coordination

The different cadres mentioned above should be registered in the professional health Councils including: The Uganda Medical and Dental Practitioners Council (UMDPC), the Uganda Nurses and Midwives Council (UNMC), the Uganda Pharmacists Council (UPC), and the Uganda Allied Health Professionals Council (UAHPC). These Councils collaborate with the Ministry of Health to carry out inspections of health care and related services in interest of the public. Registration and licensing of health professionals and health units to the Councils is compulsory and necessary for the regulation of the PHP sector.

PHPs are organized under different umbrella organizations to serve and represent their interests at different *fora.* The Uganda Private Medical Practitioners Association (UPMPA) represents doctors and the Uganda Private Midwives Association (UPMA) represents the Midwives in private practice. The membership of the other professional associations is composed of public and private health providers. The Uganda Medical Association (UMA) represents doctors, the Pharmaceutical Society of Uganda (PSU) represents the pharmacists, the Uganda Dental Association (UDA) the dentists, the Uganda National Association for Nurses and Midwives (UNANM) nurses and midwives, and the Uganda Association of Allied Health Professionals (UAAHP) the allied health workers. Other affiliate associations are also operating in the country.

8.3 Mission

The Private Health Practitioners, even under different umbrellas, share the common mission; '*To improve the quality of life and productivity of the Ugandan population by providing quality and effective health services that are accessible.*'

8.4 Contribution to the health system.

The PHP sub-sector provides a wide range of services to the population. Groups and/or individuals make decisions on what services to provide, guided by market forces in the locality. Attention is paid to affordable quality, scope, and volume of services required by the target population and the level of competition in a locality. All kinds of technologies are used, as long as the practitioners can find convenient ways of raising the capital in light of the anticipated health or medical benefits as well as the financial gains. PHPs presently operate mostly in urban and densely populated areas and are available for a wider range of hours compared to public services.[15] Drug shops, private clinics, domiciliary and home visiting services are usually the first contacts for people in need of health care. PHPs provide mainly primary level services and limited mid-level referral services. Some urban health units offer tertiary and specialist care. Curative services are widely offered, whereas preventive and Public health services are more limited, with the exception of family planning offered by three quarters of PHP facilities.

8.5 Existing collaboration

There has been limited collaboration between government and PHPs despite a greater section of the population in Uganda utilizing PHP services. Collaboration has been informal often through local innovations and arrangements between public health authorities and interested eligible PHPs in a few districts. Areas noted include:

- Provision of immunization and family planning equipment
- Provision of selected commodities to some clinics and other PHP facilities
- Sharing of theatre services with interested PHPs under mutual understanding
- PHPs participating in curriculum development together with MOH officials
- Referral of patients from PHPs to government facilities where patients benefit from services in both sectors.
- Participation to public health campaigns (immunizations, TBC and malaria control)
- Sharing of ambulance services

[15] The role of private health practice in Uganda: A critical appraisal. PPPH, 2001

9. POLICY DEVELOPMENT CONTEXT FOR THE PARTNERSHIP WITH PHP

9.1 Rationale

The private and public sectors are all engaged in health care delivery to the population. Currently the private sector is responsible for the bulk of health services in the country. However, it is recognized that each sector is inadequate on its own. Thus it is to the benefit of the population that collaboration between all sectors is institutionalised to enable access, provide quality, equitable, efficient and sustainable health services.

9.2 Specific Objectives of the Partnership with PHP

- To establish functional integration of public and private practitioners services and optimise benefits from resources available to both
- To support the sustained operation of a pluralistic health care delivery system and ensure increased access to health services mostly to the vulnerable and disadvantaged populations
- To invest in comparative advantages of the partners in order to sustain scope, quality and volume of services to the population.

9.3 Priority areas and strategies of the Partnership with PHP

The implementation of the partnership will be guided by principles in this policy. The following priority areas of partnership are defined in general and developed in detail in the Implementation Guidelines for PHP.

9.3.1 Policy and Planning

Under this area, the partnership addresses the following strategies

- Participation in policy development, HSSP monitoring and evaluation, and representation in HPAC
- Formation of a PHP Sub-Working Group to ensure PHP sub-sector involvement in policy and guidelines development, and national planning

- Government assisting PHPs to form networks through appropriate associations at different levels nationwide for better organization and response to collaboration requirements
- Assessment of PHP needs for improved service delivery
- Building capacities of PHPs on managing data, and planning at District and HSD levels
- Participation of PHPs in the District Health Planning system
- Sharing of basic health data. PHP facilities shall submit agreed basic data to the district HMIS and get a feedback.

9.4.2 Promotion of Public Health Activities.

Under this area the strategies aim to enhance greater participation in service delivery, and increase accessibility to available resources in the health sector:

- Encourage PHPs to offer public health services through Government provision of basic equipment and supplies
- Government and local authorities facilitating PHPs to participate in PHC programs and conduct out-reach activities under District supervision
- Government support to PHPs to serve remote areas
- Government providing PHPs with Information Education and Communication (IEC) materials
- Increase access to health products through PHPs
- Participation in the monitoring and supervision of health services at National and district levels
- Public awareness of scope and quality standard to expect
- Developing community based health models through supporting community based PHPs.

9.4.3 Human Resource Development

Under this area the strategies aim to benefit the partnership by encouraging:

- Government and Umbrella Organizations to sponsor basic and in-service training, and provide appropriate Continuing Medical Education (CME)

- Government to facilitate appropriate Training Needs Assessment (TNA) exercises for the private sector, and jointly sponsor courses, seminars and conferences
- PHP involvement in development and implementation of training curricula and other training materials
- Collaboration with Faculties of Medicine and other accredited medical training institutions to develop community-training sites for Continuing Medical Education
- Attachment of trainees to accredited professionals in the PHP sub-sector
- Involvement of PHPs as trainers or resource persons under training schemes in Ministry and District health programs.

9.4.4 Improvement of Referral Systems

Under this area the strategies aim to streamline the referral system and make it responsive to the needs of patients and health workers by:

- Coordination of transport and ambulance services to facilitate the referral system for delivery and emergency services
- Government to provide communication equipment such as Radio Call handsets and local radio call networks for all health providers
- Government ensuring that Hospitals are well equipped and staffed to give confidence, trust, and motivation to PHPs serving below the hospital referral facility
- Strengthening medical councils to guide members on referral guidelines
- Encouraging government to avail standard referral forms to PHPs
- Sensitizing health workers at public and private facilities to develop good attitude towards referred patients.

9.4.5 Enhancing Provision of Quality Services

Under this area the strategies aim to enhance provision of desired quality services by:

- Conform to MoH clinical and treatment Guidelines
- Awarding accreditation, to private facilities
- Facilitating PHPs to participate in monitoring and support supervision services

- Sensitizing providers, and the public about their mutual rights and responsibilities in health
- Formalizing of contracting some PHPs to provide services where need is warranted
- Instituting strict measures on quality control for all health providers and ensuring observance of set standards in service provision
- Developing Health Insurance as a stable funding source for all services
- Government to assist PHPs to acquire selected equipment and materials.

9.4.6 Regulation and Control of Service Provision

Under this area the strategies aim to address service provision by:

- Enhancing the capacity of health councils to execute their mandates
- Sensitizing PHPs on regulation standards for private facilities
- Annual publishing of licensed health facilities
- Establishing a database for all registered private providers
- Sensitization of community and civic leaders on partnership activities
- Set minimum required quality standards before issuing a license
- Establishing a graduated licensing system

Part Four

Policy Framework for Partnership with Traditional and Complementary Medicine Practitioners

PART FOUR

POLICY FRAMEWORK FOR TRADITIONAL AND COMPLEMENTARY MEDICINE PRACTITIONERS

11. SITUATION ANALYSIS

It is now becoming increasingly recognized that the healthcare system in Uganda as it stands today does not adequately address itself to solving the multitudes of health problems and concerns for all Ugandans. In this context, therefore, it is apparent that the integration of traditional and complementary medicine into the national healthcare system has the potential to augment, strengthen and promote better healthcare for all in line with the national vision. The Uganda National Health Policy recognises the role of Traditional Medicine in the health care delivery system of the country and calls for collaboration between government and the TCM sub-sector.

In Uganda, 60% of the population use traditional medicine for primary healthcare and TCM continues to enjoy widespread usage in the national healthcare system because it is much more widely available and accessible than allopathic medicine, among other factors. In addition, the ratio of TM practitioners (including traditional healers, bone setters and herbalists) to the population is between 1:200 and 1:400. This contrasts with the availability of allopathic practitioners for which the ratio is 1:20,000 or less. Finally, TM is sometimes the only affordable and available source of healthcare, especially among the poor and deprived members of our population.

This notwithstanding, there has not, till now, been an explicit national policy framework to promote, guide and regulate the utilisation of TCM in the country. Furthermore, in order to fully exploit the potential of TCM as a source of healthcare, a number of issues relating to policy, safety, efficacy, quality, access and rational use have to be addressed. This policy document attempts to address these issues and concerns and creates a formal policy environment in the above regard. The National Policy is therefore put in place with the aim to harness the potential of TCMP while at the same time preserving our medicinal heritage and the environment.

The policy defines the role of TCMP in the country's healthcare delivery system and constitutes the basis for the development of the pertinent regulatory and legal framework that will promote and maintain good practice that is accessible, equitable, authentic and safe. The policy also lays the foundation that will ensure adequate provision of financial and other resources for research, education and training in the TCMP sub-sector. Finally, it provides a framework to coordinate activities related to the development of TCMP in the public and private sectors and creates an enabling environment for the full and sustainable utilization of TCMP in addressing some of the challenges facing the national healthcare system.

11.2. Definition

This policy covers traditional and complementary medicine as far as its use and formal integration into the national healthcare delivery system is concerned. For the purposes of this policy, traditional medicine (TM) is taken to include the locally and traditionally available diverse health care practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral-based medicines, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness. ***This Policy shall not cover spirituality as a practice under TCMP.***

On the other hand complimentary medicine (for the purposes of this policy) is taken to be any other broad set of healthcare practices, (other than traditional medicine) that are not part of Uganda's own tradition and that were, at the inception of this policy, not integrated in the country's national healthcare system.

11.3 Organization and Structures of TCMP

Today, a number of institutions and organisations are involved in various aspects of TCM research, development, application and practice. Within the national research system, NCRL is spearheading research in traditional medicine and medicinal plants. Makerere University, the National Agricultural Research Organisation (NARO) and Mbarara University of Science and Technology are the other notable actors in the sub-sector, while the Uganda National Council for Science and Technology (UNCST), by virtue of its statutory mandate, provides the overall research coordination in all aspects of science and technology.

In the private sector, several TCM associations and other actors do exist, some of which have loose links with the MoH. The efforts in the public and private sectors however remain fragmented and the full exploitation and harnessing of TCM remains constrained by inadequate infrastructural provisions coupled with lack of a clear definition of roles of the various institutions. There is therefore a need to strengthen institutional mechanisms in the TCM sub-sector.

11.4 Contribution to the Health sector

11.4.1 Research and Development

There is no national research agenda in this regard and the different actors lack a coherent approach and programme to link their research to development in science and technology. What is currently on ground is mostly fragmented research whose nature and direction keep changing depending on availability of funds or institutional interests.

11.4.2 Industrial Application and Commercialisation

The potential for TCM to contribute to the national economy through industrialization and commercialization has not yet been fully exploited in Uganda. The low level of industrialisation in the country is partly responsible for this. In addition, there is no explicit policy to encourage foreign and local investment in the sub-sector. This *inter alia* calls for the establishment and strengthening of inter and intra-institutional collaboration and forging strategic partnerships and investment in research, development and commercialisation of TCM products.

11.4.2 Financing

The limited national awareness of the potential of TCM coupled with low commercial applications, and the apparent absence of a national programme for TCM development in Uganda has led to inadequate funding for the sub-sector. Public-private partnerships, joint ventures and franchises in TCM remain weak or non-existent as a result of low awareness, limited applications, and limited interaction among key players. There is need for government to put in place appropriate mechanisms to attract investment and ensure equitable resource allocation to the sub-sector.

11.4.3 Linkages and Partnerships

The development of the TCM sub-sector thrives *inter alia* on the formation of strategic alliances amongst local stakeholders on the one hand and between the local and the international stakeholders on the other. There are weak inter and intra institutional linkages in the areas of TCM. The existing linkages are mainly informal, ad hoc, and not co-ordinated. This calls for systematic development and strengthening of mutually beneficial partnerships in all aspects of TCM in the national healthcare system.

11.4.4 Public Awareness

There is limited public awareness with respect to the potential opportunities that could be tapped from TCM for the health sector. Furthermore, there is much misinformation and lack of understanding on the nature and scope of TCM. The situation is compounded by the limited documentation about the sub-sector. The real benefits of TCM have often tended to be obscured by the negative aspects. There is therefore need for Government to mobilize all stakeholders to create more public awareness of the potential of TCM.

11.4.5 Conservation of Biodiversity and Indigenous Knowledge

The TCM sub-sector largely relies on the exploitation of the country's rich biodiversity and indigenous knowledge. But there is lack of an adequate coordination mechanism between the sub-sector and other authorities within which Uganda's rich resources could be sustainably exploited for the benefit of her peoples. There is therefore need for an integrated, multi-sectoral framework to promote conservation of the local bio-diversity and utilization of indigenous knowledge for the sustainable utilization and development of the sub-sector.

11.4.6 Code of Ethics

There is an apparent lack of a generally acceptable code of ethics in various aspects of TCM Practice and product development. Ethical considerations, if any, have for long been left to the discretion of individual practitioners, institutions or associations. A well laid down code of ethics should enable the development and exploitation of TCM in accordance with acceptable moral and societal norms. This is a key factor in shaping public attitude and consumer acceptance of the products and services of TCM.

11.3.9 Legal and Regulatory Framework

To date, there is no appropriate and comprehensive legal and regulatory framework to guide, regulate and control the practitioners and practice of traditional and complementary medicine in Uganda. However, a number of statutory instruments that have a bearing on various aspects of TCM are in place. But these are scattered in various pieces of legislation, which makes enforceability difficult. Furthermore, most of this legislation is out of tune with current national and international realities and therefore needs reviewing. A policy on TCM calls for biodiversity conservation, utilization and protection of indigenous knowledge and intellectual property rights through the enactment and harmonization of relevant legislation.

11.3.10 Mainstreaming TCM

Although over half of Uganda's population use TCM as their first point of contact for primary healthcare, the sub-sector is currently not formally recognized and is not mainstreamed in the planning, implementation and monitoring systems of the healthcare system. Government needs to bring on board authentic TCM practitioners and practices in order to comprehensively address the health needs of the people of Uganda.

12. POLICY DEVELOPMENT CONTEXT FOR PARTNERSHIP WITH TCMP

In consideration of the strategic role and potential of traditional and complementary medicine in the healthcare delivery system in particular, and in national development in general, this policy intend to promote and facilitate the safe, effective, equitable and sustainable practice and utilization of TCM services and products in addressing challenges to healthcare delivery and national development with the aim of utilizing a harmoniously co-existing TCM and western medicine while preserving indigenous knowledge, medicinal heritage and the environment.

12.1 Rationale

The National Policy shall answer to a number of standing issues. In particular:

- The weak and ineffective legal and regulatory framework for TCM

- The absence of a well co-ordinated institutional framework for the promotion of TCM
- The weak linkages and partnerships between the TCM practitioners on the one hand and between TCM and allopathic practitioners
- The poor and inadequate infrastructure to facilitate TCM Research and development
- The insufficient and unreliable financing for TCM research and development.
- The limited industrial application and commercialisation of TCM processes, products and practices
- The limited public awareness of the potential of TCM
- The lack of a Code of Ethics in the TCM sub-sector
- The lack of a systematic approach to Biodiversity Conservation

12.2 Specific Objectives of the Partnership with the TCMP

To promote the development of TCM and its integration into the national health care system for achieving better health for all people in Uganda.

To contribute to poverty alleviation by enhancing household income through conservation, cultivation, harvesting and trade in medicinal plants and other medicinal resources, and contributing to national economic growth through industrialization and commercialization of local medicinal resources and practices.

To regulate and control TCM while protecting indigenous knowledge, intellectual property, consumer and other rights as well as medicinal and genetic resources.

12.3 Priority areas and strategies of the partnership with TCMP

The implementation of the partnership will be guided by principles in this policy. The following areas of partnership for the TCMP sub-sector are elaborated. Implementation shall be guided under the following areas and strategies

12.3.1. Promoting and ensuring authentic, acceptable, harmless and ethical TCM Practices

In order to achieve this objective authentic, acceptable, harmless and ethical TCM practices shall be encouraged and promoted through the following strategies:

1. Promoting research in practices of the TCMP sector.
2. Carrying out sensitisation and awareness campaigns among the public about their rights and responsibilities as far as TCM practices and products are concerned.
3. Enactment of appropriate legislation to regulate and control the practice.
4. Establishment and enforcement of a pertinent code of ethics for the practitioners.
5. Development of appropriate curricula for skills and competences necessary for TCM practices.
6. Supporting the development and maintenance of TCM service delivery, research and training facilities to appropriate standards.
7. Promoting continuous TCM education among practitioners to update their TCM knowledge, skills and competences.
8. Establishing standards and ensuring safety and hygienic working environments at the places of TCM practice.

12.3.2. Promoting research and use of appropriate methods and technologies in the TCM sector

The following strategies will be used to ensure that the methods and technology used in TCM for diagnostic examination and investigation, dispensing and administration of medicines and therapies, harvesting, preparing, packaging, and storage of medicines, research and documentation are appropriate.

1. Promotion of basic and applied research for the development of appropriate TCM methods and technologies.
2. Encouragement of appropriate TCM technology transfer within the sector and between the sector and other stakeholders within and beyond the country.
3. Develop and sustain supervision and monitoring system to encourage utilization of appropriate methods and technologies.

12.3.3. Protection and conservation of indigenous knowledge, medicinal and genetic resources and the environment.

It is imperative that indigenous knowledge, medicinal and genetic resources are protected. Furthermore, the environment needs protection against damage from hazardous TCM products and by products/practices, chemical and organic wastes.

1. Mobilization of resources for the conservation of biodiversity.
2. Promoting the use of appropriate methods of TCM and other waste disposal techniques.
3. Promotion of appropriate research in environmental protection and conservation.
4. Ensuring sustainable harvesting and use of medicinal and other resources.
5. Promotion of agronomy of local medicinal resources.
6. Putting in place legislation protect the indigenous knowledge and biodiversity.
7. Encourage and promote documentation of indigenous knowledge.

12.3.4. Promotion of Safe, Efficacious and Good Quality TCM Products

Below are the strategies to ensure that TCM products are safe, efficacious and of quality:

1. Promotion of good agricultural practices for medicinal plants and animals.
2. Promotion of good manufacturing practices for TCM products.
3. Developing nationally and internationally acceptable standards to be used for vetting TCM products.
4. Formulating and implementing an effective monitoring and evaluation system for the quality of TCM products.
5. Empowering the TCM sub-sector to set standards of product handling including packaging and storage and enforcing the same.
6. Promoting research and development aimed at improving the quality, safety and efficacy of traditional and complementary medicines.
7. Setting acceptable standards for various categories of TCM facilities and settings.

12.3.5. Collaboration and Partnerships

In order to build a strong integrated health system, the efforts of all healthcare service providers, including TCM practitioners, need to be coordinated. This policy shall promote the creation and strengthening of viable partnerships and collaboration within the sector

and with other stakeholders in order to improve the equity, efficiency and effectiveness of the healthcare delivery system through the following strategies:

1. Streamlining and strengthening the partnership between Government and the TCM sub-sector.
2. Promotion of the understanding and collaboration between the TCM and western practitioners.
3. Promotion of collaboration between the TCM and other stakeholders.
4. Promotion of collaboration among the various TCM.
5. Promoting and streamlining referral networks within the sub-sector and between the sub-sector and other stakeholders.

12.3.6 Legal Framework for Regulation, Control and Development of TCM

In order to ensure that the set standards of TCM services are improved and maintained, there is need to encourage TCM practitioners to live up to their responsibility. The following strategies will assist the practitioners to be accountable for whatever they do:

1. Encouraging continuous TCM education.
2. Registration of all TCM practitioners and practices.
3. Monitoring and overseeing the adherence of TCM set standards of services.
4. Enacting pertinent legislation that protects indigenous knowledge, intellectual property rights, and consumer rights and conforming to general human rights.
5. Establishing a pertinent statutory TCM body to promote, control and regulate TCM practice.
6. Encourage TCM practitioners to be organized under various umbrella organizations that will develop accreditation criteria for their respective members.
7. Putting in place certification criteria for TCM practitioners and facilities.

12.3.7 Promotion of Industrial and Economic Development of the TCM Sub-sector

There is a high potential for the TCM sub-sector to contribute to household poverty reduction and economic development of the country as a whole to be achieved through:

1. Putting in place legal instruments that promote and protect investments in the TCM sector
2. Mobilization of resources for industrialization of the sub-sector
3. Promotion of research for industrial development of the TCM

4. Improving on the marketing strategies for TCM products and services
5. Supporting households and other organized groups' involvement in the economic activities of the sub-sector
6. Promoting agronomy of medicinal resources.
7. Promoting collaboration between TCM sub-sector and other sectors.

12.3.8 Promote Integration of TCM into the national healthcare system

1. Carrying out sensitisation and awareness campaigns among different stakeholders about the potential benefits of TCM products and practices.
2. Promote integration of components of TCM practices into the training curricula of schools at all levels including health-training institutions.
3. Establish joint service delivery centres.
4. Advocate for inclusion of TCM as part of the national planning/budgeting, implementing and monitoring process.

12.3.9 Monitoring and Evaluation of the TCM Policy Implementation

The monitoring and evaluation of the implementation of this policy shall be the responsibility of the Ministry of Health. Other sectors will be encouraged to develop monitoring indicators that are specific to them. The following strategies are to be taken to achieve this:

1. Mobilization of resources required for the monitoring and evaluation processes.
2. Formulation of a plan to monitor the TCM policy implementation process.
3. Carrying out policy impact assessments at agreed upon intervals.
4. Dissemination of appropriate information to all stakeholders.
5. Develop, maintain and encourage utilization of a database of practices, and products for the sector.