COUNTRY CONNECTOR

Let's align for public health

Engagement of the private sector in health for the deployment of COVID-19 vaccines

a case study from Uganda

ABOUT THIS CASE STUDY

This case study was prepared by the Uganda National Health Consumers Organisation (UNHCO) and was commissioned by the Country Connector COVID-19 Working Group. The Country Connector and its working groups aim to decolonise global health by supporting local experts to tell their own stories. The study was undertaken during the period of April – June 2022 and presented during the July 2022 Working Group meeting. Here we summarise the key findings as well as questions and answers addressed during plenary discussion.

The private sector includes all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health-related goods and services. These consist of formal and informal healthcare providers ranging from drug shops to specialised hospitals, comprising for-profit and not-for-profit entities, both domestic and foreign. For the purposes of this case study, we focus on domestic private sector entities.

The COVID-19 pandemic has presented a unique opportunity for the public and private sectors to align towards public health goals. In several countries, including Uganda, the private sector role and scope is growing in the healthcare system. However, approaches to effective and sustained collaboration with the private sector in health are not well documented or disseminated. The Working Group seeks to enable more effective response to crises, optimising the whole health system through documentation and dissemination of country practice, to improve practice.

STUDY PURPOSE AND METHODOLOGY

Problem statement

Over time, there have been adequate vaccines in Uganda, but deployment challenges and vaccine hesitancy have affected rates of vaccination

Objectives

- Distil the challenges, opportunities, and best practices that arise from the collaboration between the public and the private sector on vaccine deployment in relation to the governance behaviours
- Share country experiences on the collaboration between the public and private sectors for vaccine deployment.

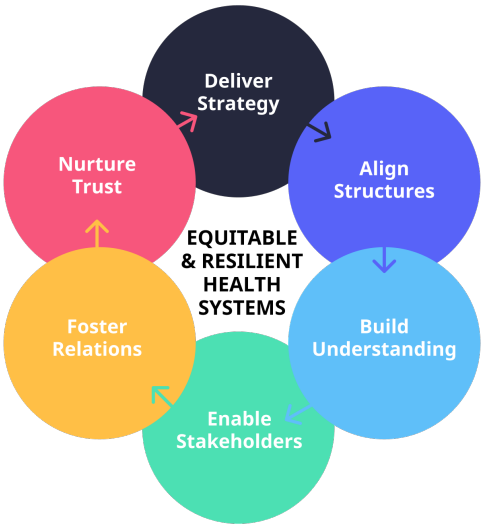

Figure 1. Governance behaviours

Methods

- Desk review and key informant interviews
- A total of 15 respondents: private sector (5), public sector (5), CSOs (3), Members of Parliament (2)
- Governance behaviours used as basis for the interview guide and analytical framework (Figure 1)

VACCINE DEPLOYMENT TIMELINE

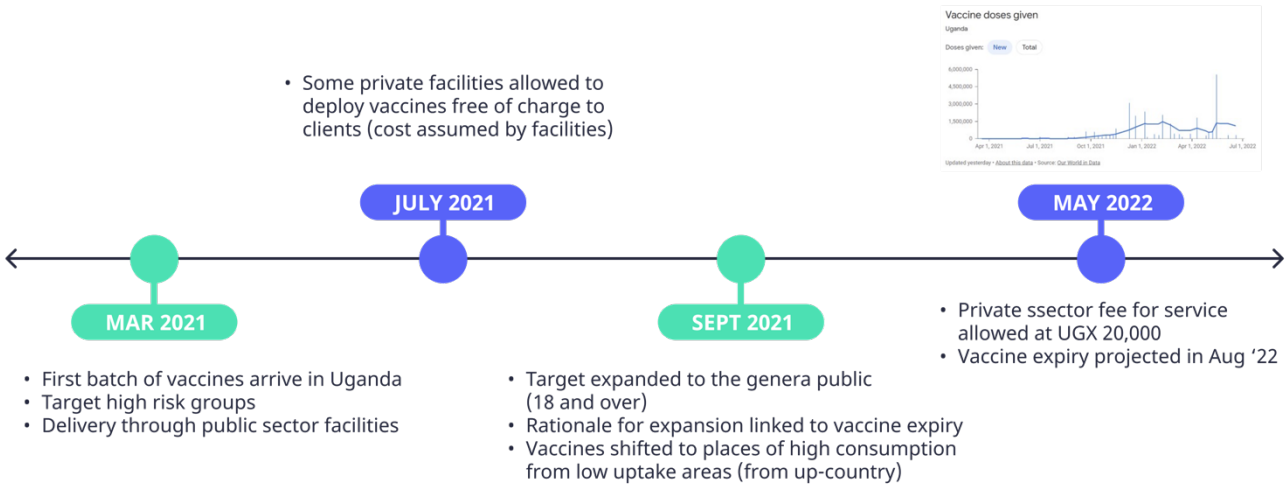

Figure 2. Timeline (Mar 2021 - May 2022)

ALIGN STRUCTURES

Alignment of public and private structures for vaccine deployment as part of the COVID-19 response

Over time, there have been adequate vaccines in-country, but deployment challenges and vaccine hesitancy have affected rates of vaccination with approximately one third of the population fully vaccinated as of May 2022.

The national COVID-19 taskforce developed a vaccine deployment plan in March 2021. This was disseminated via different platforms. There was private sector representation on the taskforce through Uganda Healthcare Federation (UHF). Vaccinations targeting high risk groups started in March 2021, but private sector facilities were not initially engaged. There were some exceptions, such Mengo referral hospital (a faith-based facility) which was engaged in March 2021, through informal channels.

There are no clear figures on how many private health facilities are currently involved in vaccine deployment or when they were engaged. The number is assumed to be few and mainly in the Central districts (Kampala and environs) and include a mix of private-for-profit, private-not-for-profit and faith-based entities.

Capacity to store and report on vaccines was indicated as a key issue and was the main decision point for engagement with private health facilities. Private sector eligibility required 'structural' assessment of vaccine storage, health worker and logistical capacity. The private sector was not prioritised for MoH training on vaccine deployment, but UHF facilitated training in 11 cities for private-for-profit and not-for-profit facilities.

FOSTER RELATIONS

Coordination arrangements and sectoral engagement for vaccine deployment as part of the COVID-19 response

Private sector coordination is concentrated in Kampala as this is where UHF and partners sit. This leaves out smaller and 'up country' private health facilities. In July 2021, Uganda National Expanded Programme on Immunisation (UNEPI) and Ministry of Health (MoH) held a press conference to officially invite the private sector to engage in vaccine deployment, promising access to vaccines through the National Medical Store.
Issues with private sector deployment soon emerged and were communicated through UHF and Uganda Medical Association (UMA) at the Public-Private-Partnerships for Health (PPPH) working group meetings. For private health entities delivering vaccines, issues of costs were raised in relation to PPE, infection prevention and operating costs (e.g., health workers, transport, allowances, etc.) Smaller facilities also complained as they were not engaged given capacity constraints.
There were concerns raised with cascade of information through the private sector and the representativeness of the private sector in committees. As noted by some case study respondents:

- *The most informed, such as civil society, are not at the table*
- *The taskforce is under the Prime Minister's office; this is not a technical forum despite having technical representation*

BUILD UNDERSTANDING

Private sector data capture and information exchange for vaccine deployment as part of the COVID-19 response

The MoH does not have a clear picture on the role of the private sector in vaccine deployment nor its contribution over time. There is "fragmented" information on private sector participation and heavy reliance on UHF which only has information from their membership. In general, there are large gaps in ICT infrastructure across the country which affects both the public and private sectors.

The data system introduced for vaccine deployment was complicated and not easily understood across public - and the few private entities – involved. Gaps in data and quality have been an issue, related to infrastructural and communication issues which has reduced timely data capture and analysis. The supply of vaccines was tagged to reporting. Those that did not report did not receive subsequent vaccine supplies. There remains a lack of information on infrastructure, training, and deployment. Given this, there was a lag in decision making and "paralysis through lack of analysis".

ENABLE STAKEHOLDERS

The development and implementation of financing mechanisms and regulations, to authorize and

No specific financing mechanisms or regulations were introduced as part of vaccine deployment (except to make COVID-19 vaccination mandatory for the population). Initially no payment was allowed for vaccine deployment through the private sector; a similar arrangement is in place with UNEPI for routine vaccination through the private sector. From May 2022, the MoH announced a

incentivize health system stakeholders for vaccine deployment as part of the COVID-19 response

standard fee of UGX 20,000 (USD $5.12) for clients to pay for vaccines through the private sector. This amount was arbitrary as no studies were done to determine if this was a fair reimbursement. It's too early to tell if this boosts deployment. *"I have to pay workers, utilities, stationary etc.",* it was felt that government should have anticipated and addressed these concerns.

NURTURE TRUST

Recognition of competing and conflictive interests for vaccine deployment as part of the COVID-19 response

The Ugandan media played a role as 'interlocutor', communicating concerns from the people and private sector to government. There were consumer complaints as they wanted the convenience of visiting the private sector for vaccines. There were private sector complaints about the cost of delivering vaccines. The government was cautious to engage on cost due to the lack of information coupled with a trust deficit with the private sector. Power dynamics were at play, which decided which private facilities were engaged in vaccine deployment, at national and district level. In some respects, this was seen as pragmatic as the ones with power are also the ones with capacity.

Vaccine hesitancy affected demand, which in turn, may have created hesitancy in the private sector to offer vaccine services. This may also have been pragmatic as the private sector didn't want to be held responsible for expired vaccines. They also didn't want to use up their storage on vaccines not deployed.

DELIVER STRATEGY

Organisational learning to improve engagement of the private sector for vaccine deployment as part of the COVID-19 response

Early engagement of the private sector (all sub-components) optimising e-communication platforms. There is a tendency to work with known entities, not looking at what private health facilities are available and where, especially those less visible (i.e., not at the table).

Vaccine deployment using a range of public and private sector facilities "de-concentrates" provision and improves access and convenience for people. It facilitates universal vaccination and the integration of private health facilities into health system preparedness and response (thinking longer term).

Delays in decision making due to lack of information, resulting in late/reactive engagement of the private sector. There is need to improve data and information through private sector engagement, don't wait for data and information to engage.

Consider fair reimbursement for private sector vaccine deployment. The government credited the private sector for free vaccine deployment, but this is costly to maintain. There is need to "stop criminalizing profit".

QUESTIONS AND ANSWERS

What is the platform for the public private partnership in Uganda? What is the contribution of the private sector?

There are different platforms including the Ministry of Health PPPH node which hosts technical working group meetings for private healthcare providers.

Another platform is the Uganda Healthcare Federation (UHF) which coordinates a sizeable number of major private healthcare providers mainly from metropolitan areas.
Private sector contributed to vaccine deployment however there is no information on this in terms of proportionate contribution.Consider fair reimbursement for private sector vaccine deployment. The government credited the private sector for free vaccine deployment, but this is costly to maintain. There is need to “stop criminalizing profit”.

During the desk review and key informant interviews, was the research team able to capture a concrete reason why MoH did not have a clear vaccine deployment plan that included private sector involvement?

The first phase of vaccination was small although the need was great therefore priority was targeted for a few high-risk populations - health workers, the elderly, men and women in uniform. Government needed time to accredit private sector entities to ensure safety. Later Government was able to work with a small number of accredited private sector entities.

Apart from government's utilization of the media channels to demystify myths related to vaccine hesitancy, does government have the necessary equipment and personnel to test the efficacy of the vaccines so that demystification can be backed by scientific evidence from the country teams?

Government is relying on WHO data regarding the efficacy of the vaccines.

What are the key recommendations from this study and what are the next action points?

To continue building trust, government should harmonise communication and share timely information, feedback and resources especially for emergency vaccine deployment with the private sector. For the private sector to recognize communication there is a need to first of all pool resources together and plan accordingly as a team.

Map out the available capacity for all the private sector entities for vaccination and support basic requirements especially in hard-to-reach areas.
Operationalise the PPPH at the district level and make deliberate effort to engage the private sector players who are not part of the UHF umbrella.

There should be a mechanism to motivate private sector to carry out vaccination including compensation for immunization costs.