INTERNATIONAL SOCIETY FOR PHARMACOECONOMICS AND OUTCOMES RESEARCH UGANDA CHAPTER

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A REPORT ON A TWO-DAY WORKSHOP ON HEALTH ECONOMICS AND OUTCOMES RESEARCH/HEALTH TECHNOLOGY ASSESSMENT

Report prepared by M. Lamorde and A. Nyabigambo

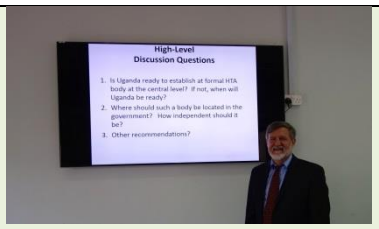
INTRODUCTION

ISPOR Uganda Chapter is based at the Research Department of the Infectious Diseases Institute Limited. The chapter is led by four executive members: Dr. Mohammed Lamorde – President, Ms. Doris Kwesiga – President elect, Agnes Nyabigambo – Secretary and Mr. Mark Ssenono – Treasurer. An objective of the chapter is to build capacity of health researchers in health economics in Uganda. In pursuit of this objective, ISPOR Uganda Chapter held a two day workshop (August 4-5, 2015) on health economics and outcomes research / health technology assessment that was led by University of Washington (Seattle, USA) Faculty, Department of Global Health.

KEY ACHIEVEMNTS

The table below summarizes the activities that occurred during the two days.

Day	Activity	Report
Day 1 (August 4, 2015)	**Attendance / welcome remarks** 	Out of 60 chapter members, 30/60 (50%) of members attended the workshop. The workshop was facilitated by Prof. Lou Garrison and Dr Joseph Babigumira. The welcome remarks were given by the chapter president who emphasized the need to grow health economics and to promote HTA in the country ((see appendix 1).
	Introduction/Overview of Health Economics, CEA	Prof. Garrison described HEOR and HTA as an approach for making better health decisions and explained its use to estimate value in the context of health care.
	Introduction to HTA	Prof. Lou Garrison described the 15 principles of HTA, the key processes and function. The key messages about HTA were the evolution, globalization, variety and challenges.
	State of HEOR and HTA in Uganda	All participants acknowledged the gap of HEOR and HTA in Uganda. It is a new field that has not been developed in the country. Members agreed that the decisions in the country are based on economic grounds rather than an economic evaluation against the country's GDP.

		
	General discussion/way forward/next steps  	17 participants were divided into two focus group discussions (FGDS) Three questions were discussed in each group and these included; 1. Is Uganda ready to establish a formal HTA body at central level? If not, when still will Uganda be ready? 2. Where should a body be located in government? How independent should it be? 3. What are the potential applications of HTA for evidence bases policy development in Uganda? 4. What factors are conducive to introducing HTA in Uganda and what are barriers? 5. What should government disinvest in and invest , what selection criteria should be used? What are the possible barriers in the disinvestment? Who should be involved ie stakeholders and target users? Group One agreed that Uganda is ready to establish HTA because there are already existing bodies like MOH to support the program if mobilized and sensitized on HTA. HTA body should be autonomous and the HTA principles must be applied in the in health care programs. ISPOR Uganda Chapter and the existing health system were suggested as the conducive environments to implement HTA. The key barrier was identified as lack of expertise in the field to facilitate the body (see appendix 2)
Day 2 (August 5, 2015)	**Modeling workshop**	The participants were trained by Dr. Babigumira on the basic principles of analysis and developing health economic models in Microsoft Excel.

CONCLUSION

The workshop enlightened participants on HTA, and it was a breakthrough to reach the realization that there is a ignored gap in HEOR and HTA in Uganda

RECOMMENDATIONS

ISPOR Uganda chapter should periodically organize HTA training sessions, conduct a stakeholder mapping of who should be involved in HTA, and also mobilize and sensitize policy makers in the country in HTA so that the body is established.

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Appendix 1

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Appendix 2: Focus Group Discussion (FGDs) State of HTA in Uganda			
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FGDS PART 1			
	HTA Question	Group 1	Group 2
	Is Uganda ready to establish a formal HTA body at central level?	A1) No- Public financing structure not yet in place. e.g. public health insurance. No-capacity, people knowledgeable in health economics. No-Education, curriculum issues - HTA not incorporated in most decision making. Institutional structure is needed to propel HTA forward. Resource HTA is expensive: Assessing all new technologies, new interventions, new products. Advocacy, politics. HTA data.	A) No, because the technical people required are not present. There's already NDA which does something similar or UNCST or NARO. There is no one looking at devices. Only drugs are regulated.
		A2) Yes, because a lot of resources are spent in purchasing health care materials and HTA is required for priority setting. Also Ministry of Health has a policy an economic evaluation department.	
	If not, when will Uganda be ready?	B) 5 - 10 years of health system reform is needed	B) Uganda can only be ready when the necessary resources are put in place. • Political will. • Manpower. • Priorities in terms of drugs and diseases. • Knowledge about HTA and its benefits. • Stakeholder engagement.

	Where should such a body be located in the government?	Ministry of health –department of planning totally independent to avoid political influence	National Medical Stores; A new independent body but part of government; National Drug Authority
	How independent should it be?	It should be semi-autonomous	It should be an autonomous body
	Other Recommendations	• Multi-disciplinary make-up without conflict interest. • Political will • Advocacy and lobbying for HTA. • formal needs asssessment is required. • Constant and consistent budgeting for HTA • Semi-autonomy • HTA body should report to another body for accountability ?IGG. • Special task force should be set up to design the HTA and identify stakeholders. • Implementation studies on HTA should be conducted in our setting	It should be made up of people from different organizations e.g. NDA, MOH, UNCST, UNACO, IDI etc with different backgrounds. It must employ research in decision making. It should take into consideration gender and cultural ideas not only economics. Other sectors outside health should also be involved e.g. communities.
FGDS PART 2			
	HTA Question	Group 1	Group 2
	What are the potential applications of HTA for evidence based policy development in Uganda	• Generate essential drugs list • Informing treatment guidelines • Determine most effective diagnostic techniques and interventions • Determining re-imbursements for health insurance schemes	• in maternal health • In child Health-vaccination. • In identifying what should be involved in the minimum health package. • Determining safe and healthy transport systems. • Determining the universal Health care who is included and costs involved.

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	What factors are conducive to introducing HTA in Uganda and what are barriers?	Conducive: Good political environment, political will, human resources and infrastructure, some financial resourdes Barriers: Lack of financial resources, health economists are scarce, HTA guidelines are lacking.	Conducive: ISPOR Uganda existence which can help us get expert help. An already existing health system and structure. Barriers: Lack of knowledge. Lack of resources. Lack of political will.
	Who are the key stakeholders and target users	A. Key stakeholders: • Health providers • Regulators • Policy makers • Legislators/parliament • Researchers • Patient organizations • Pharmaceutical companies • Training institutions B. Target users • Policy makers • Pharmaceutical companies • Decision makers at all levels • NGOs	A. Key stakeholders: • Government: MOH, NDA, UNCST • NGOs • Consumers • Private-public partnerships • Advocacy groups • Uganda National Research Organization • Foreign funders • Uganda Society for Health Scientists. B. Target users: • NMS • MOH • NDA • NBOS • Advocacy groups • NGOs

	Selection Criteria to Invest In	• Effectiveness • Cost-effectiveness • Safety • Threshold • Acceptability • Budget Impact Analysis • Replicability • Feasible • Sustainability • Coverage/Target population • Scalable • In-line with govt priorities and policies	• Cost-effective • Culturally acceptable • Equitable • Beneficial to the large segment of the population • Generalizable • Feasible and sustainable • Relevant
	Key interventions and programs to invest in	• Maternal and child health (PMTCT, immunization, skilled birth delivery, antenatal care) • Systems strengthening • Prevention intervention • Adolescent health • Sexual Reproductive Health • HTA • Agriculature	• Immunization/vaccinations • Reproductive health • System strengthening and capacity building • Communicable and non-communicable disease • Infrastructure – building of health centers • Education and sensitization of public on government health projects • Health insurance • Family planning programs • Performance-based financing
	Key stakeholders to be involved in the selection process	• Health workers • Legislators • Health economists • Health outcome researchers • Civil society organizations • Health consumers organizations	• Donors • Academia • Advocacy • Taxpayers • Public private partnerships

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	Barriers	• Lack of evidence • Poor accountability • Corruption • Political patronage • Highly centralized decision making	• Government policy – bureaucracy, corruption, lack of standardization • Poor returns on investment • Political interference • External influence by donors • Lack of adequate resources • Low research capacity
	Selection criteria to 'disinvest' in	• Ineffective • Not cost effective • Not safe • Low threshold • Not acceptable • Not replicable • Not feasible • Not sustainable • Not scalable	• Non beneficial • Not producing results • Expensive • Not culturally acceptable
	Key interventions to disinvest	• Training low-cadre health workers • Investment in level II Health Centre • Expatriate workers • Safe Medical Circumcision	• Distribution of free malaria nets • Capacity building workshops • Government vehicles procurement • Isoniazid preventive therapy • Building health centres without health workers

	Key stakeholders	•	• Public • Donors • Academia • Advocacy groups • taxpayers

Abbreviations

- FGDS – Focus Group Discussions
- HEOR – Health Economics and Outcomes Research
- HTA – Health Technology Assessment
- IGG – Inspector General of Government (Uganda)
- MOH – Ministry of Health (Uganda)
- NARO – National Agricultural Research Organization (Uganda)
- NBOS – National Bureau of Standards (Uganda)
- NDA – National Drug Authority (Uganda)
- NGOs – Non-Governmental Organization
- NMS – National Medical Stores (Uganda)
- PMTCT- Prevention of Mother to Child Transmission of HIV
- UNACO H – Uganda National Association of Community and Occupational Health
- UNCST- Uganda National Council for Science and Technology