

# Make Uganda pharmacy of Africa

**R**ecently, the National Drug Authority increased taxes on a selected list of imported medicines from 2% to 12%.

This was done as a measure to support the development of local pharmaceutical manufacturing facilities.

Indeed, this is a positive step in the right direction and in line with the BUBU policy (Buy Uganda, build Uganda) that the Government is currently spearheading.

These same measures have been implemented in many countries over the past 50 years.

Among these, is India, a country which at independence, only produced 13% of its drug requirement with the rest being imported from Europe and the US.

However, through a strategic shift in policy and government intervention India rose to become what many now know as the 'Pharmacy of the world'. As of 2001, the number of Pharmaceutical industries stood at a staggering 20,053 with a growth rate of 16% and valued at \$5.5b.

India now produces more than 90% of its medicine requirement while importing less than 10%. The sector currently employs more than 55 million people with over 134,000 jobs created annually.

Uganda on the other hand currently produces only 10% of its medicines while importing more than 90%, a stage in which India was 60 years ago. The policy shift in the Indian

pharmaceutical sector went through a number of phases that made it what it is today.

**Phase I: Establishment of foreign owned manufacturing companies (multinationals) to bring in technology to the locals**  
In the 1950s, India's pharmaceutical sector was at its infancy with hardly any production units.

The indigenous entrepreneurs at this stage lacked the capital and did not have the technology to engage in pharmaceutical production.

There was further limited support from the Indian government.

However, this began to change when incentives were put in place for multinational companies to set up local manufacturing Industries. Capital inflows increased and foreign manufacturers began to set up drug manufacturing industries.

This resulted in a threefold increase in local manufacturing output within a few years. In addition, the foreign owned manufacturing industries employed locals who acquired expertise in pharmaceutical manufacturing.

**Phase II: Set up of government owned drug manufacturing and research facilities to develop a local pool of expertise and reverse engineering technologies**

The government further realised the need to establish public sector units for purposes of bringing in technology to its indigenous



population. As a result, a number of public drug manufacturing facilities were set up.

In addition, a public sector funded drug research institute was established to boost the knowledge base that had been built from the foreign owned manufacturing facilities. As a result, 100 new process technologies were developed and transferred from the research laboratories to the industries.

Skills were further acquired by the indigenous persons in drug manufacturing and raw material production by persons who worked in the multinational companies and public sector manufacturing facilities.

**Phase III: Increasing private sector participation in drug manufacturing by the indigenous persons**

Despite these milestones, there were bottlenecks from product patent laws which hindered local manufacturing by the indigenous private sector.

To curb this, the patent act of 1970 was amended and reduced the life of patents from 16 years to 5 years and limited patents to products rather than processes.

This was done to encourage greater participation of private players in the production of drugs, because the public sector started to suffer from industrial sickness due to the lack of proper commercial orientation. Adopting the flexible provisions of the amended patent act, indigenous companies started imitating the patented product by producing generic medicines.

Eventually, they came out with better processes for the same product than their foreign counterparts and at even lower prices. Because of the competence gained by the Indian pharmaceutical companies in process engineering, the Indian companies also emerged as the major players in the domestic market.

The country also earned a reputation in the international market as a low cost producer meeting the needs of the most vulnerable.

This had a multiplier effect in other sectors as facilities began to be set up to develop and supply locally made drug manufacturing machines and accessories. The steel industry went into an exponential growth while the plastic and paper industry that supplied the sector sky rocketed in production.

**Phase IV: Quality and new drug discovery**

Despite the milestones made

in achieving great indigenous ownership and local production of pharmaceuticals concerns about the quality of medicines from India began to emerge.

To control this, the government amended its food, drugs and cosmetic act with a provision for good manufacturing practices to improve on the quality of medicines being produced. This led to new facilities coming up with standards that met the US and various European markets. In addition, India began venturing into development of new drugs away from its traditional reverse engineering.

Today, it prides itself with new drugs and exports of drugs to the US market which now stands as the largest consumer of Indian pharmaceutical exported medicines followed by the UK. As of 2014, India was exporting drugs worth \$11.7b annually with total production volumes standing at \$21b.

Uganda is endowed with a pool of highly intelligent individuals, is blessed with numerous natural resources including oil for medicine production and has a big population with an insatiable appetite for entrepreneurship.

All these are key ingredients that India used to become what it is today. What we now need is the right recipe of policies to make Uganda the Pharmacy of Africa.

**The writer is the secretary of the Pharmaceutical Society of Uganda**