

# THE MANAGEMENT OF HOSPITAL LAND IN SOUTH EASTERN UGANDA

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## **Abstract**

*Land is an important factor of production and a common reserve of financial value that keeps appreciating over time. Yet, hospitals in many developing countries do not manage their land as if it was that important. As a result, hospital land is encroached upon, used for activities that degrade its value and is often grabbed by neighbours. This study done in S.E. Uganda aimed to find out the management of hospital land in six hospitals, three of which belonged to the government. In a framework where the existing national land laws favour encroachment by long-term squatters, it found that the hospital managers had no guidelines, supervision or request for accountability on hospital land. They did not have documentation on site of the hospital land, and did not know the size or boundaries of their land. Some assumed hospital land to be managed by higher offices like the Diocesan authorities (for church hospitals) or Ministry of Health or Uganda Land Commission (for the government hospitals). Hospital land was not surveyed and had no Land Titles. District Land Boards for managing government land were non-existent or non-functional where they existed.*

*The study concludes that hospital land is at great risk of encroachment which will render future developments impossible or very costly due to the eviction of legally-protected encroachers. It recommends, among other actions, that higher authorities like the Dioceses and the Ministry of Health include the management of hospital land among the activities to be done by hospital managers right from the time of appointment. It also recommends that this aspect be considered a Key Performance Area for them during supervision and evaluation.*

## **Introduction**

As a key factor of production, as an asset whose value keeps appreciating with time and as an asset which local health service managers could manage fairly easily, hospital land is one of those assets of the health care system whose value is not documented well. In many developing countries, there is anecdotal evidence that in several public and private hospitals, this asset is mismanaged and encroached upon by hospital staff and neighbours of hospitals with or without the knowledge and complicity of the hospital managers. In Pakistan, the President gave away hospital land to a University due to failure of hospital managers to manage it properly (<http://www.dailytimes.com.pk/default.asp>.) In Uganda, the problem of land management is aggravated by poor record keeping and asset registration at hospital level and lack of support supervision, even after decentralization to the district and lower levels of government.

Land is defined as a complex system composed of topography, space, soils, minerals, water and living organisms (NEMA, 1996) or an area of ground used for a particular purpose (Macmillan, 2002). According to common law, land is conceived in such a way that the space above the ground land and everything below it belong to the land owner (Mugambwa, 2002). Land is a key factor in determining the social, political and economic base of any society. Political, economic and social power is based on land ownership (Plotkin, 1987). This is more so in predominantly agricultural societies like Uganda (Nyangabyaki, 1992). Even in Europe, land is a major concern to Governments due to a relationship between land law and public law because the rules which regulate acquisition, use and loss of land by people greatly affect political stability (Toulin and Quan, 2000).

Land is a key asset for both the rural and urban poor; forming a foundation for economic and social

activities, and the functioning of Local Governments (World Bank, 2003). Especially in poor societies, land holding patterns, terms and conditions of occupancy depend on political power, social hierarchy and economic relations (Ssenkumba, 1993). In Zanzibar, land is regarded as a means of survival and cultural identity. In many African cultures, it has great social value as a place of settlement, location, and eventual return after death; it is a symbolic and cultural asset, and a landscape for environmental services (Toulin and Quan, 2000). In Uganda, land is regarded as a source of power (Hanson, 2004). According to a household survey, 50% of Uganda's household wealth is held in form of land (Odeu, 2004). Proper management and control of land is one of the factors which can reduce land degradation and increase productivity.

Many conflicts in the world today are due to land disputes. Examples include long-standing wars and bloodshed between Israel and Palestine over the Gaza strip, wars of independence in America, Africa and elsewhere. In America there was a prolonged struggle over land use control. Land owners prevented the government and corporations from using their private land for public purposes, and the landless from using their land. This continued until 1982 when then President Ronald Reagan established a commission which led to the centralization of land use control. Similar struggles have been noted in Europe, especially England (Plotkin, 1987). In Africa, when colonialists came, they grabbed indigenous land to gain political and economic power, causing conflicts which have continued to date, for instance in South Africa and Zimbabwe (Toulin and Quan, 2000). In Uganda, colonialists grabbed indigenous tribal land through so-called agreements with local chiefs in exchange for peace (Buganda Agreement of 1900, Toro Agreement of 1900, Ankole Agreement of 1901, Bunyoro Agreement of 1933); the rest of the land in Uganda, where there was no accessible system of government to make an agreement with, was declared Crown (read the British King's) Land.

In Uganda, land disputes exist between individuals, within families, between tribes and with the state. Examples of land disputes include the conflicts between Buganda and Bunyoro over the 'lost counties' - Bunyoro counties which the colonialists gave to Buganda as a reward for support in fighting a resistant Bunyoro king, the 1990 uprising in Sembabule and others (Odoki, 1994; Anguzu, 2004; Nyangabyaki, 1992; Dungu, 1994).

In Africa, originally, all land was managed under indigenous customary arrangements by Kings, Clan

heads, traditional chiefs and elders. They governed land using broad principles which were relevant to the pre-industrial economies relying on kinship as a primary organizing factor. On the advent of colonialism, all land was declared Crown Land a practice which was inherited even by the post-colonial governments to their advantage (Toulin and Quan, 2000; Bruce and Migot, 1994).

Colonialists also imported their laws into Africa to enhance their interests. All existing customary land laws were subjected to, and in most cases replaced by, colonial common laws under the concept of "Received law" which was enforced on Africans. This was through their process of destruction, substitution, replacement and integration. They also struggled for urban plots through displacing Africans. Examples are the Dualla in Cameroon who were expelled from the prospective European city and in Tanganyika, where Africans were removed from their homes, put under communal villages and declared landless (Toulin and Quan 2000).

### Historical Perspectives on land

In Uganda, land was originally owned customarily. On becoming a British protectorate, British land law was super imposed upon existing land tenure systems, and undermined some of its social benefits (Nyangabyaki, 1992; Ssenkumba, 1993; Mugambwa, 2002).

In Uganda, therefore, land management can best be described in three phases i.e. pre-colonial, colonial and post-colonial periods. During the pre-colonial period, in areas where kingdoms existed, the kings theoretically held paramount land titles on behalf of their subjects. They were assisted by clan heads in administration of such kingdom land (Dungu, 1991; Nyangabyaki, 1992; Ssenkumba, 1993; Kaggwa, 1994; Mugambwa, 2002). Outside kingdom areas, land was owned communally and administered according to other customary laws.

During the colonial period, land ownership and control of use of most of the land was removed from kings and clans and given to the colonial state. This created different land tenure systems, some of which continue to exist to date. In Buganda, possibly the most organized kingdom in Uganda at the time, the *Mailo* (land patches taken from the control of the kingdom) tenure system was superimposed on the semi-feudal arrangements formerly operating under the entire ownership of the king (Nyangabyaki, 1992; Ssenkumba, 1993; Kaggwa, 1994). Similar practices occurred in other kingdom areas of Uganda, where

the colonial government signed agreements which granted estates to a few cooperative chiefs and the rest of the country was declared waste and uncultivated land to be under the Crown (Toulin and Quan, 2000; Mugambwa, 2002). In 1902, the Uganda Order defined Crown Land as all public lands which were subject to the control of his Majesty's Government, and all land acquired for public purposes (Mugambwa, 2002). In 1903, the Crown Lands Ordinance was enacted to provide for the manner in which Crown land was to be allocated by the Governor. This was to be through Leasehold and Freehold. Freehold was to operate under several restrictions (Mugambwa, 2002; Ssenkumba, 1993).

The Crown Lands (Declaration) Ordinance of 1922 further emphasized the Crown's duties over land outside the unoccupied areas, land acquired for public purposes, and that covered by agreements. It stated that all land in the protectorate was presumed to be Crown Land unless stated otherwise. Thereafter until the termination of the Protectorate, the legal position was that, outside Buganda, all land which was not held under title was Crown land. Such land was at the absolute disposal of the Governor and held by him on behalf of the African occupiers (Mugambwa, 2002; Ssenkumba, 1993).

In the post colonial period, land management by the government started with the 1962 Constitution when the first Land Commission was established together with Land Boards for each federal state and each district. The Land Commission was mandated to manage all government land in Uganda. It was backed up by a Public Lands Act of March, 1962. The terms of the Land Commission were renewed in the 1966 and 1967 Constitutions of Uganda. After the abolition of kingdoms, the 1967 Uganda Constitution added together those estates which were originally held under the Official Estates Act, land formerly under Kingdoms and District Land Boards to official government land. In 1969, a Public Lands Act set up a Public Land Commission as a body corporate and vested in it, all titles and interests in public land. It also protected customary tenants such that land occupied by them could not be alienated without their consent, compensation and resettlement (Ssenkumba, 1993; Nyangabyaki, 1992).

In 1975, during the military regime of Amin, the government made a Land Reform Decree which declared all land in Uganda as public land. It repealed all former land tenure systems except leasehold. This decree was, itself, repealed by the 1995 Constitution which restored the former post-1962 land tenure

systems (Bruce and Migot, 1994; Ssenkumba, 1993; Mugambwa, 2002). Currently, land in Uganda is managed according to the 1995 Constitution and the 1998 Land Act, which provide for three bodies responsible for the management of land. The Uganda Land Commission is responsible for the management of government land. The department of Lands and Surveys is responsible for surveying and demarcating boundaries, an action which is the major protection of land against encroachment. The Ministry of Lands is responsible for issuing Land Titles.

However, one major problem with the management of government land in Uganda still persists. Before the 1995 Constitution came into force, all land in Uganda was public land, according to the 1975 Land Reform Decree. Therefore, there was no need to demarcate specific chunks as government land. This was repealed by the 1995 Constitution without making any provisions for demarcation of government land. In absence of any clear boundaries of government land, therefore, encroachment became the order of the day (McAuslan and Mwebaza, 1999). One of the government institutions that suffered this encroachment greatly was the hospitals. What should be of concern to hospital managers, therefore, is that CAP 227 of the 1998 Land Act protects tenants and encroachers on other people's land by providing for compensation if they have stayed on it for at least twelve years before the 1995 Constitution (Government of Uganda, 1998).

### **Management of Hospital Land after Decentralization**

Hospitals in Uganda are of two types: government and private (mostly faith-based private-not-for-profit or private for profit). For government general (formerly 'district') hospitals, the Uganda Land Commission is responsible for all government land as the supreme body, assisted by different hospital management bodies for each hospital. These include the District Local Council, the Hospital Management Board/Committee and the Hospital Management Team in that order. The District Local Council is the final decision making body on all land issues in the district (MOLG, 1997). The Hospital Management Board/Committee is the policy-making and overseer of all hospital management activities including land. The Hospital Management Team is responsible for the day-to-day management of hospital assets including land.

In church-founded hospitals, hospital land is part of the general church land. It is managed by dioceses, specifically Diocesan Health Boards and Diocesan Land Commissions in some cases. In some church-founded

hospitals, the hospital is allowed to use church land under the immediate management of the parishes. At times, the priorities of the parish and those of the hospital differ and the hospital is always the loser. In one such case, the parish planted trees for commercial purposes on land allocated to the hospital. Though the hospital is allowed to use the land, it is not allowed to cut the trees to put up development projects (Discussion with one of the PNFP hospital managers, 2003). Private-for-profit hospitals generally own land under one of the existing nationally recognized private tenure systems of either *Mailo*, freehold or leasehold.

### State Ownership of Land

Post-independence African governments inherited land tenure systems of the colonial governments and have, to a large extent, maintained the status quo at independence. A few exceptions have been noted in Tanzania and more recently in Zimbabwe. The World Bank avers that governments should have the right of compulsory land acquisition with compensation, for the broader public benefit. However the way in which many developing countries do it especially for urban expansion, undermines security of tenure and often little or no compensation is paid. Paradoxically, however, the state, especially in developing countries, lacks the necessary capacity for satisfactory management and utilization of land yet large tracts of land continue to be under state ownership and management (World Bank, 2003). Shortage of administrative capacity forces many developing countries to rely disproportionately on a regulatory rather than a fiscal approach to land management. Unlike most government officials, private residents neighbouring the hospitals recognize the huge economic importance of hospitals in their areas and thus take all advantage of unutilized hospital assets such as land. Hospitals provide a ready market for food, accommodation and essential commodities needed by the staff, patients and attendants (Maniple et al., 2004). Having land near a hospital therefore is an investment that many shrewd entrepreneurs try to invest in, even if it means fraudulent expropriation of hospital land.

There exists a lot of undeveloped land (government and private) in many peri-urban areas in Uganda. The World Bank advises that such land should be auctioned to investors and compensate the original owners. In the case of Uganda, many hospitals are also located in urban areas and have such undeveloped land around them. However, before they were constructed, the government compensated the then land owners, some of whom have now encroached on their former land.

This is a challenge to hospital managers who have idle and poorly demarcated land. The World Bank further argues that where idle public land has been occupied by poor people in good faith for a long time and significant improvements have been made, such rights should be recognized and formalized at a nominal cost to avoid negative equity outcomes (The World Bank, 2003). An additional challenge for Ugandan hospital managers is that Uganda's Land Act of 1998 provides that if someone had stayed on the land for at least twelve years before the coming into force of the 1995 Constitution without being contested, such a person is a *bona fide* occupant of the land and cannot be removed without compensation.

In Uganda, most government land is not demarcated since before the 1995 Constitution all land was public land (McAuslan and Mwebaza, 1999). Almost ten years after the enactment of the 1998 Land Act, the Uganda Land Commission has not yet demarcated government land boundaries. The Land Registry is not organized and land records get stolen or tampered with on a regular basis (Mugambwa, 2002). At district level, according to the 1998 Land Act each district is supposed to have a Registrar of Titles at sub-county level. However this is still more theoretical as none exists in districts and the process of registration of land titles is still centralized, with the effect that most poor people in rural areas cannot afford the costs of land registration. The result is that most land in Uganda does not have titles and, for fraudulent commercial purposes, most of the few titles that exist are held by people other than the genuine owners of the titled land.

In many parts of Uganda, the resolution of conflicts is still inefficiently handled as some districts still lack District Land Tribunals. In addition, the Tribunals are not supposed to handle cases valued above Uganda Shillings fifty million, yet all hospital land is valued beyond this. Therefore disputes over hospital land are handled by high courts, but then their case is always weakened by lack of documentary evidence due to poor records management.

### Land Management and Tenure Systems in Uganda

Land management in Uganda is based on both the Constitution of the Republic of Uganda, 1995; and the Land Act of 1998. Chapter 15 of the Constitution provides for land under Articles 237-243. In Article 237 (Land Ownership), the Constitution returned land ownership to the people of Uganda. However basing on Article 26 of the Constitution, the government could, on compensation, acquire land in public interest such as public health concerns like a hospital. There

are four recognized types of ownership (tenure systems) in Uganda, namely, Customary, Freehold, Mailo and Leasehold. The Customary land tenure system is regulated by customary rules and regulations whose operations are limited to a particular group and description of people. The Mailo land tenure system means holding registered land in perpetuity, and having roots in the allotment of land as per the 1900 Buganda Agreement, and subject to statutory qualifications. The Freehold land tenure system means holding registered land outside Buganda in perpetuity, subject to statutory and common law qualifications. The Leasehold land tenure system means holding land for a given period from a specified date of commencement on such terms and conditions as may be agreed upon by the lessor and the lessee. The hospitals under study fall in an area under freehold tenure since it is found outside Buganda.

Under the 1998 Land Act, all government land is managed by the Uganda Land Commission (ULC) through its subsidiaries, the District Land Boards and Sub-county Land Recorders. The ULC has the authority to sell or lease any government land, including hospital land, where it may deem necessary. An example is land for Butabika National Referral Hospital which the ULC has leased to private developers. However, interpretation of this authority seems to differ, with some analysts arguing that the ULC is just a Trustee and should not take major decisions over such land without the consent of the user department, which is the true owner of the land (Okello-Okello, 2004).

Implementation of the land management structure has been slow. Many districts still do not have the required Boards and Tribunals. The Act did not specify who was supposed to appoint District Land Boards and how they were to operate. Its implementation required an enormous amount of money since it created many new structures including District Land Boards, Land Tribunals, Parish Land Committees, and Land Recorders with full time staff countrywide. Even if it had been affordable, the costs would still outweigh benefits (McAuslan and Mwebaza, 1999). Other barriers to effective implementation of the Act included a shortage of staff with the appropriate knowledge of land matters at local level. The Act was amended in 2001 authorizing the districts to appoint District Land Boards but the amendment only came into force in 2004. By the end of 2004, only 4 (7.1%) out of the 56 districts then operative in Uganda had appointed DLBs. Moreover, none of these felt that they had a role in the management of hospital land.

Some authors have argued that there is need for a specific Government Land Act for government land to regulate the management of government-owned and government-occupied land (McAuslan and Mwebaza, 1999).

### **Management of Land Records**

Good management goes with proper records management. In Uganda however, the management of land records management is poor. The land registry is in a very poor state, land offices are understaffed, under-equipped, staff are underpaid and demoralized. The registry records are all manual, hard to retrieve and in a very poor state. The extent of damage and inaccuracy is hard to estimate but cannot be underestimated (Mugambwa, 2002). Another observer noted that about 15% of Uganda's area records are in a poor state, outdated, very expensive to access, and not well protected against disaster. The country could easily lose information as old as 100 years (Odeu, 2004).

However, the government planned to invest up to US\$20m over five years starting from 2004, towards rehabilitating the existing land records, establishing a land information system and to implement a phased decentralization of land registry records (The New Vision, 11/6/2004). The land registry would be computerized so that Land Titles bear the fingerprints and photographs of owners, to reduce on cases of land tenure forgery and corrupt tendencies of junior staff at the Land Registry (New Vision, August, 2004).

### **Management of Hospital Land**

For public hospitals in Uganda, Hospital Administrators are responsible for the management of all hospital assets, including land (MOH, 1996). Medical Superintendents are the accounting officers for hospital assets while Hospital Management Boards/Committees are the overseers of all hospital management activities and a policy making body for hospitals (MOH, 2003a). However, no activities have been specified that must be implemented by any of these authorities. This lack of clarity is noted in other countries as well. In Pakistan, a hospital lost land due to failure to manage a parking site for 600 cars and new 300,000 sq.ft piece of land. As a result the President gave it to the University of Health Sciences. (<http://www.dailytimes.com.pk/default.asp>.)

### **Study of Hospital Land**

A descriptive, cross-sectional and largely qualitative study was conducted in five purposively selected then existent South Eastern Uganda districts of Iganga, Mayuge, Jinja, Tororo and Kamuli from May to September 2004. The study area is bordered by Kenya

in the east, Mbale in the north east, Kumi and Soroti in the north, Mukono in the west and L. Victoria in the south. To avoid conflict of interest, Bugiri District was excluded because it is the workstation of the author and Busia District was excluded because it did not have a recognized hospital. The study area is predominantly occupied by peasant farmers and has a high population density.

Although the said districts had nine hospitals in all, only six hospitals were studied. These were Iganga, Jinja and Tororo Government hospitals and St. Francis Buluba, St. Anthony Tororo and Kamuli Mission NGO hospitals. All the NGO hospitals are private-not-for-profit (PNFP) and founded by the Catholic Church. Selection of hospitals was based on the fact that S.E Uganda has only three PNFP hospitals and it was therefore desired to get an equivalent number from Government for comparison purposes. Of the three Government hospitals selected, two were general (formerly called 'district') hospitals and one was a regional referral hospital. The regional hospital was included to see if there was a difference in management of land at different levels of the health system. Thirty key informants were interviewed. All were selected purposively as because of their involvement or knowledge in the management of hospital land matters. They were Medical Superintendents, Hospital Administrators, Chairpersons of Hospital Management Committees/Boards, District Land Officers, Municipal/Town Clerks/Engineers (Government hospitals), Diocesan Health Coordinators, Diocesan Land Boards, Secretary Uganda Land Commission and Ministry of Health staff (Senior Assistant Secretary and an Engineer from the Health Infrastructure Division).

In trying to establish the size of hospital land in PNFP hospitals, where the data given by hospital managers differed from those given by dioceses and documents could not be accessed to validate the figures, diocesan figures were taken as more authentic since official land records are supposed to be kept at diocesan level. Data were collected by observation of the land boundaries, interviewer-administered questionnaires and review of land transaction records. One recognized limitation of this study is that the so-called encroachers were not interviewed to hear their side of the story.

## Findings

### *Guidelines*

It was found that no guidelines specific for the management of hospital land existed either at hospital level (for both government and PNFP hospitals), at

Ministry of Health level or even at the Uganda Land Commission. However, at Diocesan level, written general guidelines on utilization of church land existed but they were not distributed to hospitals, which therefore limited their usefulness. For the PNFP hospitals, although the guidelines were easily accessible at diocesan level, only one Hospital Administrator was on record to have bothered to consult and use them.

### *Site plans*

In order to know the delimitation of the hospital land, a hospital should have a site plan showing the boundaries and key features of the land. Such a plan should be kept at the site for regular consultation by the managers. All Government hospitals had Site Plans at hospital level. For missionary hospitals, none had a site plan at the hospital and only one hospital reported to have it but it was kept at the Diocese. Other hospital managers were not aware of the existence of the Site Plans for their hospitals whereas, in fact, they also existed at diocese level. This may imply either lack of interest or lack of management knowledge in hospital land issues by hospital managers in PNFP hospitals.

### *Development/Master Plans*

For organized and planned development, an institution needs to have a master plan to avoid setting up structures in the place of would-be future developments. Such a plan should also be kept at the hospital for regular consultation during development of new structures. Only 2 of the 3 government hospitals and none of the PNFP hospitals had a master plan on site.

At Ministry of Health level, there existed a National Health Infrastructure Development Plan consisting of detailed drawings, specifications and Bills of Quantities for the standard building plans for all levels of health centres and hospitals (MOH, 2003b). One general hospital and the Regional Referral hospital had a copy. In the hospitals where these plans existed, they were being utilized to guide new developments and they were quite recent (dated May 2003). These hospitals were also on schedule for renovation by Ministry of Health either through government efforts or through projects. In the only PNFP hospital where a development plan existed at diocese level, it was always used during the construction of new buildings.

### *Size of hospital land and its utilization*

Most hospital managers did not know the actual size of the land owned by their hospitals and had no records from which this information could be obtained easily. Some of the land was under use and some was idle or encroached upon as shown below:

| Hospital           | Level             | Ownership | Land Size                                        | Land under Use             | Idle land                                            |
|--------------------|-------------------|-----------|--------------------------------------------------|----------------------------|------------------------------------------------------|
| Jinja              | Regional Referral | Public    | Estimated at 40 acres                            | Estimated at $\frac{3}{4}$ | Estimated at $\frac{1}{4}$                           |
| Tororo             | General           | Public    | 41,000m <sup>2</sup> + unsurveyed land           | Not available              | Not available                                        |
| Iganga             | General           | Public    | 22.8 acres, surveyed                             | Estimated at $\frac{3}{4}$ | Estimated at $\frac{1}{4}$ and is under encroachment |
| St. Francis Buluba | General           | Church    | 39.77 acres surveyed, but estimated at 900 acres | Not available              | Nil                                                  |
| Kamuli Mission     | General           | Church    | Estimated at between 30-40 acres                 | Whatever is accessible     | Unknown. It is under squatters                       |
| St. Anthony Tororo | General           | Church    | 2.6 acres, surveyed                              | $\frac{1}{4}$              | $\frac{3}{4}$ staff gardens, encroachment & idle     |

Large areas of hospital land remained idle and unutilized or was encroached upon by neighbours and squatters. Most land of the PNFP hospitals was fully utilized either for buildings or agricultural and other income-generating activities.

In Government hospitals, land is generally occupied by buildings.

#### ***Safe guards to hospital land***

Surveying of land is the best protection against encroachment. This is among the first steps towards land titling. Of the 3 government hospitals studied, only 1 had a title for its land and none of the 3 PNFP hospitals had a title at the hospital. In the only government hospital where a title existed, it was partial and did not include some of the land which was being contested by encroachers. However, the managers were in the process of acquiring a complete title including the contested land. All the PNFP hospitals had their land titles kept by their Dioceses. Apart from one Hospital Manager, the rest were not even aware of the existence of Land Titles for the hospitals they manage. In the government hospitals, apart from one hospital which had a partial title on station, not even a copy of titles of the land of the other hospitals could be traced at MOH headquarters level.

Another safeguard for hospital land could have been erection or planting of landmarks and fences. All hospitals had a fence in one way or another. However, only one government hospital was fully fenced off with a chain link fence backed by a hedge. Others were partially fenced, using just barbed wire or a chain link fence.

Apart from the one Government hospital which was fully fenced, all hospitals reported a problem of encroachment from the neighbouring community. In one PNFP hospital the squatters were so hostile that they threatened the life of the Hospital Administrator and hindered expansion of hospital activities. The situation was so grave that the hospital could not even get land to construct a latrine and separate the out-patients' department (OPD) from wards in order to reduce the number of visitors on wards during working hours. In one Government hospital, expansion plans were hindered by other people who claim the same land.

However, in the Government hospital which was fully fenced, the hospital staff used hospital land for their private gardens for long such that even when they left the hospital on retirement or transfer, they continued holding on to the land.

In another government hospital, they had a problem of increased thefts and intrusion by domestic animals due to lack of a fence.

#### ***Roles and contribution of different parties in management of hospital land***

The Study Area fell in two Catholic Dioceses. In one diocese, all developments in the hospital had to be done in consultation with the Diocesan Health Coordinator's office. It was the Coordinator's duty to ensure all hospitals possess Land Titles and are fenced well. All records concerning hospital land were kept by that office. In another diocese, the Diocesan Health Coordinator had no role to play in management of hospital land. The Coordinator only got to know of a hospital's land problems during a hospital's Board

meeting where s/he is a member. The current Coordinator had never seen any document concerning hospital land. One diocese had a Diocesan Land Commission which was set up to safeguard church land including hospital land from encroachers, squatters, and unauthorized sale. It processes and ensures renewing of Land Titles for leased church land. It gave guidelines on the utilization of church land, and ensured that hospitals can only utilize church land according to their needs, but can not sell, lease or lend it without the consent of the Diocese.

The role of the Ministry of Health in the management of hospital land had changed after decentralization. Whereas it was the custodian of hospital land in the past, it currently only had a nominal role in policy making, utilization, technical and supervisory roles in general hospitals. In regional hospitals, however, it still plays a big role in the management of their assets. The ministry had no specific department handling hospital land matters but was aware of the rampant encroachment on hospital land and that for lower level health units.

#### ***Comparison of practices in Government and PNFP hospitals***

In government hospitals, although the hospital managers are expected to manage the hospital assets including land, they are not given any guidelines for land management.

Support from the Ministry of Health only comes in for deciding on the utilization of the land for major developments. Municipal/Town Councils work hand in hand with hospitals when putting up new developments on hospital land. Their engineers give guidance on where to place new developments basing on hospital Site/Development Plans. Cases over land worth more than US\$ 30,000 must be handled in the High Court. Only Jinja Diocese (hosting Buluba and Kamuli hospitals) had ever taken a case over hospital land to a court of law. None of the six Hospital Boards had ever made any policy on hospital land yet they were fully involved in the management of hospital land issues.

In the PNFP hospitals, land management was centralized at Diocese level. Only one of the three administrators interviewed was aware of his role in land management. The others were not even aware that their Dioceses had a policy on hospital land. Record keeping on land was very poor in PNFP hospitals. All PNFP hospitals did not have any records of their land hospital land on site. Apart from one, the rest had never taken any interest in hospital land issues.

In both government and PNFP hospitals, there were no regular checks on land boundaries. In PNFP hospitals, most hospital managers felt that land management was a duty of the Diocese.

Generally, PNFP hospitals utilized whatever land was at their disposal fully, their only hindrance to utilization being squatters and encroachers. Whatever land was not under buildings, was fully used for crop and animal farming. Hospital managers were not aware of the existence of land titles for their hospitals and their presence could not be verified.

#### **Discussion**

The study found that there were no guidelines on land management at different levels of the government and PNFP system. For the PNFP hospitals, only general guidelines on the management of all church land existed, but there was nothing specific for hospitals. Guidelines are necessary for proper management because they show how the authorities expect the managers to perform. They are more important especially for new managers. In addition to the lack of guidelines, the study observed that the legal framework is inadequate to protect hospital land and in fact could act in favour of encroachers on the same. All these are problems that favour the mismanagement of hospital land. The fact that the only hospital manager (PNFP) who knew of the existence of guidelines also utilized them implies that if they had existed in other hospitals, they could have also been utilized for better management of hospital land.

All Government hospitals had Site Plans at hospital level. This is in agreement with Pearson's recommendation that hospital sites should always have room for expansion (Pearson, 1995). Expansion is at times necessary for provision of services of better quality. It provides for more room to separate services, provide privacy, provide new services etc. Therefore, having site plans helps in planning development of the institution and avoids scattered developments which may waste land or lead to more expensive development later in order to avoid pre-existing developments where the two may not be compatible. However, only one PNFP hospital reported to have a Site Plan and even this was kept at the diocese. This suggests poor management of land because the managers of all the hospitals should have obtained, at least, copies of the land they manage. In the absence of the site plans and Master Plans, it is difficult for the managers to accurately follow up the utilization of the land and any encroachment. It is even harder to follow up court cases about the land successfully.

In 3 (50%) of the 6 hospitals studied, the actual size of hospital land could not be objectively studied. It was therefore difficult to identify what portion of hospital land was idle or encroached upon. The managers could only estimate the size, because either some land was not surveyed or there were simply no records. Even where a land title existed, it was only for part of what is known to be hospital land. Therefore the actual size reported was only for the surveyed part. This implies that most hospital managers did not know the size of land (and therefore the amount and value of the assets) for the hospitals they manage. This makes it difficult to be good stewards of the hospitals.

In government hospitals, unutilized land was left idle and therefore more liable to encroachment, compared to PNFP hospitals where most of it was used for income-generating activities. The problem could be related to the difficulty of deciding to use public land for income-generating activities, a decision which may have to pass through many bureaucratic channels, unlike in PNFP hospitals. Where attempts were made to use idle government land, health workers seem to have taken advantage of the weak control mechanisms and used the land for private purposes even after they were transferred from those units.

It was surprising that most hospitals did not even have titles (or at least copies of titles) for the land they manage. The managers of government hospitals could argue that obtaining the titles for the land is a function of the Uganda Land Commission but we contend that the process must be initiated locally. Some PNFP managers were not even aware of the existence of or of the need for these titles.

### Conclusions

The study exposed weaknesses in the management of the assets of both government and private-not-for-profit hospitals. There is poor documentation of the assets, poor use of the existing records, lack of guidelines on asset management from the higher authorities and little knowledge and interest on the part of the managers. These weaknesses provided ground for mismanagement of hospital land and other assets by staff, managers and neighbours of the hospitals. Evidence of poor management included lack of land titles, lack of master plans, lack of site plans, use of land by long-transferred staff, encroachment by neighbours and squatters, litigation for double compensation etc.

The weaknesses in management are at both the hospital level and at Ministry of Health or Diocesan levels. During the handover processes, land was not handed over as an asset to new managers. Especially for government hospitals, there is still lack of a relevant specific legal or policy instrument for the management of hospital land. The local managers still expect the overarching Uganda Land Commission to do the detailed follow-up of government land, a role which should be performed by the local managers. The existing laws leave large room for encroachment on public land and even protect the encroachers. In both the government and the church-founded hospitals, the existing policies and laws do not properly expound the roles and responsibilities of each level in the management of hospital land, thus leading to neglect.

### Recommendations

It was recommended that the government, through relevant bodies like the Uganda Land Commission and the Ministry of Health, could prepare specific instructions to different levels of government on the management of hospital (and other institutional) land. This would detail, among others, the responsibilities of the different land management bodies and charge the hospital managers with a specific responsibility to manage hospital land. Performance in this aspect by the hospitals could, for a given period of time, be a feature in the support supervision programmes. For PNFP hospitals, similar instructions could come from the dioceses. The instructions could cover the land surveying, obtaining of titles, acquisition of more land, alternative uses for idle land, the custody of land documents, institution of new developments on the land etc.

It was also recommended that Hospital Boards and managers need to get more actively involved in issues concerning land for the hospitals they manage than is currently the case. Their involvement could cover regular inspection of the use of the land, monitoring the boundaries for encroachment, fencing to prevent encroachment, education of the neighbouring public about the importance of respecting the borders of hospital land and its relationship with quality of care, proper maintenance of land documentation, respect of hospital master plans etc.

## References

- Anguzu R. (2004), *Banyoro want Lost Counties and not Federo*. The New Vision. 11<sup>th</sup> August, 2004, p.22.
- Bruce J.W and Migot S.E (1994), *Searching for Land Tenure Security in Africa*. Kendau/Hunt Publishing Co.
- Daily Times (2003). *The hospital has failed to manage the 300,000 sq. ft piece of land*. Site Edition. (Web version) issue 11<sup>th</sup>, November. <http://www.dailytimes.com.pk/default.asp>
- Dungu E. (1991), *A Review of the MISR-Wisconsin Land Tenure Centre Study on Land Tenure and Agricultural Development in Uganda*. **Working Paper No.11**, CBR Publications
- Dungu E. (1994), *The Other Side of Land Issues in Buganda: The Pastoral Crisis and the Squatter Movement in Sembabule Sub-district*. **Working Paper No. 43**, CBR Publications.
- The Republic of Uganda, (1998), *The Citizens' guide to the Land Act, 1998*. Kampala: The New Vision.
- Hanson, E. Holly (2004), *Landed Obligation: The Practice of Power in Buganda*. Social History of Africa. Heinemann Publishers.
- Kaggwa B.J. (1994), *Land Tenure and Land Use in Kampala District*: **Working Paper No. 45**. CBR Publications.
- Macmillan Publishers (2002), *Macmillan English Dictionary for Advance Learners*, 1<sup>st</sup> edition.
- McAuslan and Mwebaza (1999), *Land Act Implementation Study: Legal Appraisal, Annex 6, draft report*. 2<sup>nd</sup> August, 1999.
- Ministry of Health, Uganda, (2003a), *Guidelines on Hospital Management Committees for District Hospitals*, Department of Quality Assurance
- Ministry of Health, Uganda, (2003b), *Presentation on Health Infrastructure Development at the National Health Assembly 2003*: At International Conference Centre Kampala.
- Ministry of Local Government (MOLG), Uganda, (1997), *The Local Government Act*.
- Mugambwa J.T (2002), *Source Book of Uganda's Land Law*. Fountain Publishers, Kampala
- National Environment Management Authority, Uganda (1996), *The State of Environment for Uganda Report for 1996*.
- Nyangabyaki Bazaarra (1992), *Land Policy and the Evolving Forms of Land Tenure in Masindi District, Uganda*. **Working Paper No. 28**, CBR Publications
- Odeu S. (2004), *Land Registry Mess slowing Estate Development*. The New Vision, 22<sup>nd</sup> July p.19.
- Odoki B.J (1994), *Statutes on Uganda Land Law*. Kampala: LDC.
- Okello-Okello (2004), *Who really owns that Butabika land?* The New Vision 8 June, 2004.
- Pearson C.A (1995), *Medical Administration For Frontline Doctors: A Practical guide to the management of district-level hospitals in the Public Service or in the Private Sector*. 2<sup>nd</sup> edition
- Plotkin S. (1987), *The Struggle for Land Use Control*. University of California Press.
- Ssenkumba (1993), *The Land Question and the Agrarian Crisis': The Case of Kalangala District, Uganda*. **Working Paper No. 34**, CBR Publications
- The New Vision (2004), *Land Registration, Budget Speech 2004*. 11<sup>th</sup> June 2004, pg.10
- The Republic of Uganda (1995), *Constitution of the Republic of Uganda*. Reproduced by LDC.
- Toulin C. and Quan J. (Eds), (2000). *Evolving Land Rights, Policy and Tenure in Africa*. (National Resources Institute). DFID, London, UK
- World Bank (2003), *Land Policies for Growth and Poverty Reduction: A World Bank Policy Research Report*. A Co-Publication of World Bank and Oxford University Press.