Uganda's Herbal Medicine Heritage

From Import Dependency to Health Sovereignty: Investing in Uganda's Herbal Medicine Heritage

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Abstract

Africa carries a disproportionate burden of global disease yet manufactures only a fraction of the medicines it consumes. This paper presents an advocacy case for investment in Ugandan herbal medicine research, regulation, and manufacturing as a pathway toward health sovereignty. We examine the economic costs of pharmaceutical import dependency, confront the deeper philosophical stakes of how African medical knowledge is named and valued, highlight documented success stories, and propose specific policy interventions to transform Uganda's herbal heritage into a regulated, standardized, and economically viable healthcare resource. Before making that economic and policy case, we first set out the language we use throughout this paper and why: precise, self-defined terminology — African herbal medicine, African indigenous knowledge, African medical knowledge system, African ethnomedicine, and African pharmacopeia — in place of the single catch-all "traditional medicine," and we explain why that choice of words is itself a matter of justice, not style. Drawing on the theme "From Import Dependency to Health Sovereignty: Investing in Uganda's Herbal Heritage," we argue that investing in African herbal medicine is not merely a health intervention but a justice imperative that honors African indigenous knowledge, creates economic opportunity, and strengthens national self-reliance. We further argue that government leadership is the non-negotiable first step in this pathway — the only actor that can supply the legal certainty, regulatory standing, and public trust that any other investor will require before committing capital — while making the case that government funding alone cannot carry a sector of this scale, and that a deliberately built coalition of diaspora capital, impact investors, philanthropic and faith partners, research funders, and traditional institutions must be recruited alongside it. This imperative demands a sustained, organized, multi-generational advocacy campaign, not a single appeal.

1. Introduction: Why This Conversation, Why Now

The African Traditional Medicine Awareness Week convenes researchers, policymakers, traditional healers, and pharmaceutical stakeholders around one urgent question: how does Africa strengthen local research, innovation, and manufacturing of medicines — including African herbal medicine — to reduce dependence on imported pharmaceuticals?

The answer matters because illness does not wait. Somewhere in Uganda, right now, a patient is being treated for malaria, for hypertension, for a difficult birth. Investing in home-grown medicine is not a bet on a future problem — it is a response to a need that never pauses. The question is not whether to invest in African herbal medicine, but when and how much. Every day of delay costs lives and opportunities.

2. Language and Naming: Why "African Herbal Medicine," Not "Traditional Medicine"

Before this paper makes its economic and policy case, it is necessary to explain the words it uses to make that case, and to explain them in more depth than a simple glossary allows. Language is not decoration — it is the first site where value is assigned or withheld. This section sets out that logic up front, first as a practical framework and then as a philosophical argument, so that every reference to plant-based African medicine that follows is precise about what kind of claim it is making: a claim about a product, a claim about knowledge, a claim about a system, a claim about a scholarly field, or a claim about a documented formulary.

2.1 The Problem With a Single Catch-All Term

Our medicine is routinely called "traditional." The same plant-based science practiced in Europe is called "herbal medicine" or "phytomedicine." This distinction is not neutral — it shapes which products are trusted, which are funded, and which command higher prices on the shelf and in the clinic. A single umbrella term also flattens five genuinely different things — a manufactured product, a body of community knowledge, a system of diagnosis and care, a field of scholarship, and a codified formulary — into one word that invites all of them to be dismissed together as unscientific or informal.

This paper therefore retires "traditional medicine" as its default term and replaces it with five deliberately chosen terms, each doing a specific job. Together they form the vocabulary used consistently throughout the remainder of this paper.

2.2 A Five-Term Framework for Precision

African Herbal Medicine

The plant-derived medicinal product itself — the bark, root, leaf, or seed preparation once it is formulated into a usable dose: an extract, tincture, capsule, tablet, or tea prepared for a specific condition. This is the direct African counterpart to what is called "herbal medicine" or "phytomedicine" when the same category of plant-based product is made in Europe or Asia.

Use when: Whenever referring to the formulation, preparation, or manufacturable/manufactured output — the physical medicine itself, whether harvested at farm gate, sold in a market, or standardized into a clinical product.

African Indigenous Knowledge

The broader, orally transmitted, community-held body of knowledge that a formulation comes from — diagnostic reasoning, preparation methods, and generations of accumulated observation, held collectively by healers, elders, and communities, independent of whether it has yet become a marketable product.

Use when: When discussing knowledge holders, knowledge transmission, protection of that knowledge, informed consent, intellectual property, and benefit-sharing — anywhere the paper is protecting or crediting the people and communities who hold the knowledge, not describing a product.

African Medical Knowledge System

The full institutional and epistemological framework within which African indigenous knowledge operates: diagnosis, therapy, prevention, apprenticeship and practitioner training, and community health infrastructure, considered as a coherent system of care rather than a loose collection of remedies.

Use when: In academic, comparative, and decolonization discussions — anywhere this paper argues that African healing deserves recognition as a system on equal epistemic footing with biomedicine, rather than as a supplement or "alternative" to it.

African Ethnomedicine

The term that situates this body of knowledge and practice inside the internationally recognized academic field — ethnomedicine, ethnopharmacology, and ethnobotany — the peer-reviewed, cross-cultural, comparative scholarly discipline already used worldwide to study plant-based medical systems.

Use when: In academic writing, citations, publications, grant applications, and engagement with international scientific bodies — it signals rigor and places Uganda's work in the same vocabulary the global research community already uses.

African Pharmacopeia

The codified, standardized, documented formulary that African herbal medicine and African ethnomedicine research should ultimately produce: monographs identifying species, standardized dosages, quality parameters, safety data, and clinical indications — serving the same function a national pharmacopeia serves for conventional pharmaceuticals.

Use when: When referring to registries, national or institutional formularies, National Drug Authority documentation, and the eventual standardized output of the research and validation pipeline described in Section 5.

2.3 The Deeper Stakes: Why Naming Is an Act of Justice, Not Just Style

It would be easy to treat Section 2.2 as a matter of house style — a glossary to be skimmed before the "real" argument begins. That would misread what is happening when a word is chosen. Words allocate belief. They tell a listener, before a single fact is examined, how much scrutiny to extend and how much trust to withhold. This is the insight of the philosopher Miranda Fricker, who describes ***testimonial injustice*** as the wrong done when a hearer gives a speaker's word less credibility than it deserves because of who the speaker is, and ***hermeneutical injustice*** as the wrong done when a whole community lacks the shared concepts needed to make its own experience intelligible to others, [1]and the word "traditional" performs both at once. It tells the listener in advance that whatever follows is custom rather than knowledge, belief rather than evidence — and it does so before a single formulation has been tested.

The Portuguese sociologist Boaventura de Sousa Santos gives this pattern a name: ***epistemicide*** — the destruction of ways of knowing that accompanied the destruction of peoples and cultures under colonialism, carried out not only through violence but through the everyday, bureaucratic act of deciding which knowledge counts as knowledge at all. [2]Uganda's herbalists were never short of knowledge. What they have been short of is the institutional power to have that knowledge recognized as knowledge in the first place — the same kind of power that, as Section 2.4 recounts, once decided which African leaders were permitted to be called kings.

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[1]Miranda Fricker, Epistemic Injustice: Power and the Ethics of Knowing (Oxford: Oxford University Press, 2007).

[2]Boaventura de Sousa Santos, Epistemologies of the South: Justice against Epistemicide (Boulder, CO: Paradigm Publishers, 2014).

This is not an abstract grievance. It has a concrete economic mirror. The Beninese philosopher Paulin Hountondji described how African science and African raw materials suffer the same fate: both are exported unprocessed — the plant as bark, the insight as raw testimony — and both return, transformed and validated, only after passing through a laboratory or a university abroad. He called this pattern extraversion: an economy of knowledge oriented outward, so that African data feeds foreign theory-building while African institutions do the collecting, not the concluding.

Hountondji's account of scientific [3]extraversion is, in fact, the philosophical twin of the economic argument this paper makes about Prunus africana in Section 4: a Ugandan harvester supplies the raw material; a European laboratory supplies the validation, the patent, and the profit; and the finished product returns to Uganda as an import. The same structure that extracts value from Uganda's forests also extracts credibility from Uganda's healers. Both are corrected the same way — not by asking the world to take African knowledge on faith, but by building, at home, the laboratories, the peer review, and the regulatory institutions capable of doing the validating ourselves, so that the finding and the credit for the finding never have to leave the country at all.

Godfrey B. Tangwa, a Cameroonian philosopher of medicine, sharpens this point further: the danger is not merely that African healing is called "traditional" while European herbal medicine is called "phytomedicine." The deeper danger is applying the standards and categories developed within one scientific tradition as if they were the neutral, universal test for all of them — a move that can quietly repeat the intellectual patterns of invasion and conquest even when no one intends harm. [4]Tangwa's point is not that African medicine should be exempt from rigorous testing — this paper argues throughout that it must be tested, standardized, and validated. His point is that the terms of comparison must themselves be negotiated rather than assumed, so that testing African medicine against a foreign standard does not become, by default, another way of declaring it inferior before the results are in.

Alex Broadbent, in Decolonizing Medicine, situates the same problem inside the philosophy of science: the question of what counts as "medicine" is inseparable from the question of who holds the power to define medicine, and colonial medicine was never simply more effective than the systems it displaced — it was also backed by the administrative and military power to declare itself the only legitimate system. [5]Recognizing that history does not settle any clinical question about whether a given African herbal medicine is safe or effective — only rigorous testing can do that. But it does settle a prior question: who gets the benefit of the doubt while the testing is underway, and whose knowledge is presumed valid until disproven versus presumed worthless until proven otherwise. That presumption is set, in large part, by a single word.

2.4 A Historical Parallel

During colonial rule in Ghana, African rulers were barred from being called "kings" or "queens" — titles reserved for the British monarchy — and were renamed "traditional chiefs" and "queen mothers." The relabeling did not change the institution, but it changed how the institution was treated and valued in law, in diplomacy, and in the colonial administration's own record-keeping. The same demotion-by-renaming is

[3]Paulin J. Hountondji, "Scientific Dependence in Africa Today," Research in African Literatures 21, no. 3 (1990).
[4]Godfrey B. Tangwa, "How Not to Compare Western Scientific Medicine with African Traditional Medicine," Developing World Bioethics 7, no. 1 (2007): 41–44.
[5]Alex Broadbent, "Decolonizing Medicine," chap. 9 in Philosophy of Medicine (New York: Oxford University Press, 2019), 209–238.

available today, in the same region of the world, for medicine. We should not repeat that pattern with our medicine.

2.5 A Call for Standardized Language

Our ask: standardize this five-term vocabulary nationally and continentally, using African herbal medicine, African indigenous knowledge, African medical knowledge system, African ethnomedicine, and African pharmacopeia alongside their Western counterparts — not beneath them. This ensures that scientific, legal, and commercial recognition are pursued on equal semantic footing, and it is the vocabulary this paper uses from this point forward. Precision in language does not replace the scientific and economic case that follows — it is the foundation that makes that case possible to hear on its merits.

3. The Economic Case: What Africa's Pharmaceutical Dependency Costs Today

3.1 The Continental Picture

The structural imbalance in global pharmaceutical production is stark. Africa carries approximately 25–26% of the global disease burden while producing only about 3% of the world's medicines. [6]Roughly 60–70% of medicines consumed on the continent are imported, primarily from India and China, and figures for active pharmaceutical ingredient (API) import dependence range from roughly 90% to over 95% depending on the country and study — even in countries that only package or finish-blend locally.

Estimates of the Africa pharmaceutical market's value and growth trajectory vary by source and methodology; publicly available industry analyses place the market in the range of roughly US$27–29 billion in the mid-2020s, projected to approach or exceed US$50 billion by 2030. [7]This represents a significant outflow of foreign exchange that could otherwise be retained within African economies.

This imbalance is not incidental — it is structural. Every dollar spent on an imported tablet is a dollar that could have paid a Ugandan researcher, farmer, or factory worker instead.

3.2 Uganda's Medicine Import Bill

Uganda still imports the large majority of the medicines it uses. Reported figures for Uganda's annual pharmaceutical import bill vary by data source and year: UN Comtrade data placed pharmaceutical imports at roughly US$507 million in 2023, while industry and press accounts drawing on Uganda Bureau of Statistics figures have cited a nearly doubled bill of approximately US$500–534 million between 2019 and 2023. [8]Whichever figure is used, the direction and scale are consistent: a substantial and growing drain on foreign exchange reserves and a missed opportunity for local economic development.

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[6]African Union Development Agency (AUDA-NEPAD), 24 Priority Medical Products and Roadmap for Regional Manufacturing in Africa (January 2025).

[7]See, for example, Brookings Institution, "Realizing Africa's Pharmaceutical Potential" (2026), which cites market growth from approximately US$20.8 billion (2013) toward a US$50 billion 2030 projection; figures differ across industry reports and should be treated as directional rather than precise.

[8]UN Comtrade international trade data, as compiled by Trading Economics, "Uganda Imports of Pharmaceutical Products" (accessed 2026); cross-referenced against Uganda Bureau of Statistics external trade statistics bulletins. The precise figure is contested across sources and should be treated as an order-of-magnitude estimate rather than a settled number.

The economic calculation is compelling: if well-researched, standardized African herbal medicine formulations displaced even 20–30% of that import bill, Uganda would retain roughly US$100–150 million a year circulating in local cultivation, processing, and pharmacy jobs. This is a conservative, evidence-based estimate grounded in existing data, not a projection of miracle cures.

4. The Cost of Forgetting: A Cautionary Case Study

4.1 Prunus africana: Exporting the Cure, Not the Value

Prunus africana — the African cherry — grows in Uganda's montane forests and has treated prostate and urinary conditions within African indigenous knowledge for generations. Estimates of the global market built on this species vary sharply depending on what is being measured: scientific literature on the raw bark-extract commodity trade puts that market in the single-digit millions of dollars annually, while broader industry estimates of the retail value of finished over-the-counter prostate-health products that include Pygeum/Prunus derivatives run far higher, into the hundreds of millions. [9]This paper flags that discrepancy rather than resolve it: the honest and cautious claim is that Prunus-derived products anchor a valuable, multi-hundred-million-dollar global category of prostate-health remedies, even though the specific bark-extract commodity itself trades for far less.

Yet on either measure, Uganda captures almost none of this value.

The current value chain operates as follows:

- Ugandan harvesters collect bark from forests and farms, paid at the farm gate for as little as US$2–6 per kilogram — and comparable studies from neighboring bark-exporting countries have found harvesters receiving under US$1 per day of harvest work, [10] a small fraction of the price the finished bark extract commands once processed.
- The bark is shipped to Europe, where two firms based in France and Italy process approximately 86% of the world's bark extract for pharmaceutical use.
- Finished capsules are sold worldwide in dozens of trademarked products, returning to Uganda as expensive imports.

This pattern raises serious concerns about benefit-sharing. Reports indicate that harvesters receive low wages, with the bulk of value captured by a small number of international processors. There are also documented concerns about the lack of respect for African indigenous knowledge and rights over the pharmacological knowledge of Prunus africana as a medicinal plant.

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[9]Compare C. Cunningham et al., "The African Cherry (Prunus africana): Can Lessons Be Learned from an Over-Exploited Medicinal Tree?" (bark-extract trade estimated near US$4–5 million per year) with industry retail-market reports that estimate the broader finished OTC prostate-health product category, of which Pygeum is one ingredient among several, in the hundreds of millions of dollars. This is a genuinely contested figure and readers should treat any single number with caution; the two estimates are not measuring the same thing.

[10]See G. Bodeker, C. van 't Klooster and E. Weisbord, "Prunus africana (Hook.f.) Kalkman: The Overexploitation of a Medicinal Plant Species and Its Legal Context," Journal of Alternative and Complementary Medicine 20, no. 11 (2014): 810–822; and R. Ingram and E. Nsawir, "Power, Policy and the Prunus Africana Bark Trade, 1972–2015," Forest Policy and Economics (2015), documenting net farm-gate returns of well under US$1 per kg after intermediary margins.

The lesson is not that Prunus africana should stop being harvested — it is that Uganda can and must capture this value at home. Without local processing, standardization, and manufacturing capacity, Uganda's forests fund pharmaceutical companies abroad more than they fund Ugandan health or livelihoods.

5. The Value of Remembering: Evidence Already Exists

5.1 The Knowledge Base Is Already Here

Approximately 70–80% of people in the WHO African Region have used African herbal medicine as primary health care. In Uganda specifically, an estimated 60% of the population seeks care from traditional and complementary medicine providers before, during, or after visiting the formal health sector, [11]relying on it for its accessibility, affordability, and cultural familiarity.

The ratio of traditional health practitioners to people in Uganda is approximately 1:200–400, compared to approximately 1 doctor per 20,000 people.

This is not merely a historical curiosity — it reflects a living, adaptive African medical knowledge system that has sustained African communities for generations. It is also, on current trends, at risk: Uganda has been named among the countries facing the highest threat of herbal-medicine-knowledge extinction as elder knowledge-holders are not replaced by a new generation of documented practitioners.

5.2 Food Was the First Herbal Medicine

What we eat from nature already sustains health. The missing step is transforming that everyday African indigenous knowledge into measurable, standardized doses — capsules and extracts prescribed for specific conditions, the same way any modern medicine is. This requires:

- Consistent research and documentation
- Peer review and testing
- Development funding
- Industrialization of pharmaceutical production

Individuals with African indigenous knowledge, for the most part, lack the funding necessary to take this knowledge to the next step — testing and retesting, developing the regimens needed, and standardizing dosages into an African pharmacopeia. This is precisely the gap this paper is written to close, and it is why Uganda's own preservation efforts — including university-linked awareness and documentation projects such as the 2024 Commonwealth-supported indigenous-medicine workshop in Entebbe — matter as much as any single clinical trial. [12]

[11]UNICEF Uganda, "Traditional Healers, Key Allies in Promoting Positive Social and Behaviour Change in Communities" (2023), citing joint UNICEF–Ministry of Health risk-communication data on traditional and complementary medicine provider (TCMP) usage.

[12]Commonwealth Scholarship Commission in the UK, "Promoting Indigenous Medicinal Knowledge in Uganda" (May 2024), describing a community training and documentation workshop led by Ugandan Commonwealth alumnus Dr. Akusa Patrice Mawa in Entebbe and citing WHO estimates that over 80% of the African population relies on traditional medicine.

5.3 Emerging Ugandan Success Stories

Recent developments demonstrate growing momentum in Uganda. In mid-2026, media reports described President Museveni endorsing herbalist David Ssenfuka's decade-long work on cancer and diabetes formulations, reportedly calling it a national treasure and signaling government willingness to fund further development; the President is quoted as saying that government has resources it sometimes spends on less useful things, and asking how it could fail to help people like Ssenfuka and others like him who need assistance. [13]Following a State House meeting on 30 June 2026 between the President, the Inter-Religious Council of Uganda (IRCU), and Ssenfuka, the IRCU publicly endorsed continued research into the formulations while explicitly calling on government to tighten regulation to weed out fraudulent herbal practitioners. [14]A group of elders and former public officials — including former Chief Justice Samuel Wako Wambuzi — has separately urged faster processing of promising herbal remedies for non-communicable diseases, joining the board of a foundation established to support Ssenfuka's research. [15]

This momentum extends beyond any single herbalist. In 2024, traditional healers and herbalists from more than 18 organizations across Uganda formed a new umbrella body, the Re-Union of Traditional Healers and Herbalists Association, explicitly to unify standards and curb quack practitioners; the Uganda Herbalists Association, whose chairperson also sits on the National Drug Authority board, reported over 300 registered herbalists at the time, and called on government to provide land for cultivating medicinal tree species threatened by climate change. [16]And in a notable example of a traditional institution acting as a regulatory partner rather than a bystander, the National Drug Authority signed a memorandum of understanding with the Buganda Kingdom, under which the Kabaka agreed to champion safe drug use and the Kingdom agreed to work with the NDA to train herbalists and help them access Good Manufacturing Practice standards. [17]Taken together, these developments show a sector that is organizing itself — practitioners, elders, faith leaders, and cultural institutions are all already moving. What is missing is not willingness. It is capital and a funded regulatory pipeline to match it, which Sections 8 and 9 address directly.

6. Policy Momentum Already Exists

Uganda has laid the groundwork — it now needs resourcing.

6.1 Existing Policy Framework

[13]Uganda Observer, "Ssenfuka's Cancer, Diabetes Drugs Win Museveni, Clergy Support," 15 July 2026. Note: some secondary reference lists date this story to 2025; the article's own publication metadata and a related, earlier 2025 Observer piece on the initial Museveni endorsement suggest the underlying story developed across mid-2025 and mid-2026 as separate reporting; readers consulting the primary source should note the July 2026 date on the article itself.

[14]Daily Express Uganda, "Religious Council Backs Senfuka's Indigenous Cancer Medicine, Urge Scientific Validation," 9 July 2026; see also The Standard News, "IRCU Backs Indigenous Herbal Research, Calls for Scientific Validation of David Ssenfuka's Diabetes and Cancer Remedies," 8 July 2026.

[15]Uganda Radionetwork, "Herb Used to Treat Cancer, Diabetes Gets Nod from Elders, Former MPs." This story's own site metadata is inconsistent with its content, which references 2026 developments; the reporting should be treated as recent (2026) coverage rather than dated precisely, and is included here with that caveat in the interest of factual transparency.

[16]Uganda Radionetwork, "Traditional Healers Form Association." As with the item above, the site's displayed date does not align with the 2026 policy environment the story references; treated here as a recent development pending independent date verification.

[17]Uganda Broadcasting Corporation, "National Drug Authority Signs Memorandum of Understanding With Buganda Kingdom," 17 October 2023.

Year	Policy/Act	Significance
2000	Uganda National Health Policy	Formally recognizes African herbal medicine's role in healthcare delivery
2014	Industrial Property Act	Restricts patenting of medicines
2019	Traditional & Complementary Medicine Act	Creates National Council to register and license practitioners; set practice standards; awaiting full implementation
Ongoing	Natural Chemotherapeutics Research Laboratory (NCRL)	Uganda's dedicated public research body for medicinal plants — the natural home for expanded funding
2025–34	WHO Global Traditional Medicine Strategy	Sets the international framework Uganda can align national investment against

The policy architecture exists on paper. What is missing is a funded research and manufacturing pipeline to make it real.

6.2 Implementation Gaps

Former Agriculture Minister Victoria Sekitoleko has observed that the Traditional and Complementary Medicines Act was "dead on arrival" because it was placed under the Ministry of Health — which reportedly has not prioritized its implementation. She has called for a separate ministry dedicated to complementary and alternative medicine. [18]

Masaka District health authorities are now rolling out registration of traditional healers and birth attendants as one approach to addressing maternal deaths. [19]This local-level engagement demonstrates the potential for coordinated regulation and integration, and the new Re-Union of Traditional Healers and Herbalists Association described in Section 5.3 shows the same appetite for self-regulation building at the national level.

Jamil Mukwaya, Chairperson of the Uganda Herbalists Association and a member of the National Drug Authority board, has stated that traditionalists and herbalists should know it is no longer business as usual after the enactment of the Traditional and Complementary Medicine Act.

7. Protecting What's Ours: Intellectual Property and Benefit-Sharing

7.1 The Legal Gap

Uganda's Industrial Property Act (2014) restricts patenting of medicines, leaving the Trade Secrets Protection Act as practitioners' main — and weak — fallback for protecting formulations. This creates uncertainty that discourages practitioners from sharing African indigenous knowledge and investors from funding research.

7.2 The Trust Gap

[18]Uganda Radio Network, "Former Minister Seeks Special Ministry on Indigenous Medicine."
[19]Daily Monitor (Kampala), "Masaka Authorities to Register Traditional Healers, Birth Attendants," 29 October 2024.

Herbalists have resisted aspects of the 2019 Act, fearing that disclosure requirements for standardization could expose African indigenous knowledge without protecting who owns it.

7.3 The Fix

Pair any regulatory disclosure requirement with enforceable access-and-benefit-sharing rules — so communities and practitioners share in the value their knowledge creates, not just exporters. Access and Benefit Sharing (ABS) agreements may contribute to the sustainable exploitation and use of wild products such as Prunus africana.

Strong intellectual property and benefit-sharing law is what turns future African herbal medicine exports into shared prosperity rather than a repeat of extraction — and, as Section 9 argues, it is also the single legal reform that most determines whether private investors beyond government will treat Uganda's herbal sector as investable at all.

8. What We Are Asking Government to Do

The five investments below are the floor, not the ceiling, of what this sector needs — and they are deliberately sequenced first, because none of the additional capital described in Section 9 will arrive until government has put them in place. A private investor cannot license a product that has no legal pathway to registration. A philanthropic funder cannot underwrite research with no public laboratory to conduct it in. A diaspora investor cannot build a factory on land with no protected medicinal-plant supply chain. Government is not one funding option among several; it is the precondition for all the others.

8.1 Five Investments That Would Change the Trajectory

1. Fund the research pipeline

Direct budget line for the Natural Chemotherapeutics Research Laboratory and university units (Gulu, Makerere) to move promising remedies from documentation through clinical testing and into the African pharmacopeia. Current gaps in funding prevent practitioners from taking African indigenous knowledge to the next step of scientific testing and standardization.

2. Finish and resource the 2019 Act

Fully implement the National Council; give it a budget to license practitioners and set enforceable safety standards. The Act's current status as "awaiting full implementation" leaves practitioners and patients in regulatory limbo.

3. Legislate benefit-sharing

Enact access-and-benefit-sharing rules so knowledge-holders and communities profit alongside investors and exporters. This addresses the trust gap that currently prevents practitioners from sharing formulations.

4. Incentivize local manufacturing

Provide tax incentives and Good Manufacturing Practice (GMP)-upgrade incentives for domestic standardized African herbal medicine production. The National Drug Authority has already signaled that

increased verification fees on imported drugs are designed to encourage investment in Uganda's growing pharmaceutical manufacturing sector.

5. Protect the raw material base

Fund cultivation and conservation of medicinal plants under commercial pressure. Prunus africana, for example, is now listed among endangered species protected by the Convention on International Trade in Endangered Species (CITES) regulations. Cultivation and sustainable harvesting are essential to ensure supply outlasts demand.

9. Beyond the Treasury: Building a Broader Investment Coalition

Government investment is necessary. It is not sufficient. Uganda's national budget, even fully committed to every request in Section 8, cannot alone fund a research pipeline, a manufacturing base, and a conservation program at the scale this sector needs. The honest case for African herbal medicine is therefore not a case for government money alone — it is a case for government-anchored money that pulls in everyone else.

9.1 Why Government Must Lead, No Matter Who Else Invests

Before naming other investors, it is worth being precise about why none of them can substitute for government, and why government's role does not shrink as other capital arrives — it becomes more important, because it is what makes the other capital safe to deploy.

- **Only government can create legal certainty.** A pharmaceutical company, a diaspora investor, or a development bank will not commit capital to a formulation that has no lawful pathway to registration and sale. The 2019 Act, once fully resourced, is what converts a promising remedy from a legal grey area into a licensable product — no private actor can substitute for that.
- **Only government can set and enforce quality standards.** Investors price risk. An unregulated sector is priced as high-risk, which either repels capital entirely or invites the wrong kind — opportunistic buyers looking to extract cheaply rather than partners looking to build. A credible National Drug Authority standard is what allows a legitimate investor to tell the difference between a validated product and an unproven one.
- **Only government can protect the shared raw-material base.** Prunus africana and other CITES-listed or at-risk species are a commons. No individual investor has an incentive to conserve a shared forest resource; left unmanaged, competing private interests will harvest it to exhaustion, as very nearly happened already. Only a state with regulatory and enforcement power can make conservation binding on everyone at once.
- **Only government can legislate benefit-sharing that investors must honor.** Without an enforceable access-and-benefit-sharing law, a private investor's promise to "share value" with knowledge-holders is voluntary and revocable. Government is what makes that promise a legal obligation rather than a marketing claim — which is also what protects investors themselves from later accusations of exploitation.
- **Only government carries the legitimacy to convene traditional authority.** The Buganda Kingdom's 2023 memorandum of understanding with the National Drug Authority, described in

Section 5.3, was possible because a state regulator and a cultural institution recognized each other as counterparts. A private company cannot easily replicate that convening power, and public trust in a remedy is built through exactly this kind of institutional partnership, not through advertising.

This is the sequencing argument at the heart of this section: government leadership is not one input alongside private capital — it is the input that de-risks every other input. A mining-sector parallel is instructive here, and this paper returns to it more fully in Section 10.2: African countries that failed to establish clear extraction, taxation, and local-content rules before opening mining sectors to private capital ended up with foreign-dominated, low-value extraction; those that built the regulatory floor first captured more value from the same resource. Uganda's herbal sector is at the point in that story where the floor still needs to be built.

9.2 A Map of Investors Beyond Government

With that foundation understood, the following investor categories are realistic sources of capital that a government-led regulatory framework would unlock — not replacements for government, but partners it can now credibly recruit.

Diaspora and Ugandan private capital

Uganda has a large, often high-earning diaspora with direct personal stakes in the country's health outcomes and a demonstrated appetite for backing indigenous medical innovation — herbalist David Ssenfuka has reported that his search for support extended to American investors interested in his cancer and diabetes research after he sought help from international contacts, including a direct appeal to the former United States government. [20]A structured diaspora bond or diaspora investment vehicle, dedicated to African herbal medicine research and manufacturing and backed by the credibility of a functioning National Council, could convert individual goodwill into pooled, patient capital — something no single philanthropic gift or government grant reliably provides on its own.

Impact investors and development finance institutions

Pan-African pharmaceutical manufacturing is already attracting blended and development finance: the African Development Bank has estimated that roughly US$11 billion in investment will be needed by 2030 to grow Africa's local pharmaceutical manufacturing sector, and has already backed concrete local-manufacturing projects elsewhere on the continent, including Emzor Pharmaceuticals in Nigeria and open-access research infrastructure in South Africa. [21]Uganda's herbal pharmacopeia work is a natural fit for this category of financing precisely because it is import-substitution investment with a measurable foreign-exchange return — the kind of case development finance institutions are already built to evaluate.

Pharmaceutical and nutraceutical manufacturing partners

Contract manufacturing, licensing, and technology-transfer partnerships — the same models already used for API production elsewhere on the continent — allow an established pharmaceutical or nutraceutical company to invest in Ugandan processing capacity in exchange for supply security or licensed distribution rights,

[20]Uganda Observer, "Ssenfuka's Cancer, Diabetes Drugs Win Museveni, Clergy Support," 15 July 2026, reporting Ssenfuka's account of American investors expressing interest in funding his research.

[21]African Development Bank estimate, as reported in Gavi/VaccinesWork, "Africa Imports Over 70% of Its Medicines. Making Active Ingredients Locally Would Change This" (2025/26), also citing a 2023 €14 million European Investment Bank facility for Emzor Pharmaceuticals in Nigeria and CSIR's FuturePharma open-access facility in South Africa as comparable precedents.

without requiring government to build a factory itself. A resourced National Council and a credible pharmacopeia are what make Uganda's herbal formulations legible to this kind of partner in the first place.

Philanthropic, faith-based, and diaspora giving networks

Uganda's faith institutions are not bystanders to this cause — the Inter-Religious Council of Uganda has already publicly and repeatedly endorsed indigenous medical research and called for both increased government support and tighter regulation, as detailed in Section 5.3, giving any funding appeal a ready-made, trusted local validator. Beyond individual congregations, organized regional philanthropic infrastructure already exists to be tapped: the East Africa Philanthropy Network connects more than 200 member organizations and a wider partnership base of thousands of institutions across Kenya, Uganda, Tanzania, and Rwanda, and has an explicit mandate to channel local and diaspora giving toward development priorities. [22]A campaign that approaches EAPN's network directly — rather than relying on ad hoc appeals — stands a far better chance of reaching philanthropic capital already organized and looking for credible local partners.

University, research, and alumni-funder partnerships

International scholarship and alumni bodies are already funding small-scale indigenous-medicine documentation and training in Uganda — the Commonwealth Scholarship Commission supported a 2024 community workshop on preserving indigenous medicinal knowledge in Entebbe, led by a Ugandan alumnus. These programs are modest individually, but they demonstrate an existing, replicable funding channel: international research and alumni bodies willing to fund documentation and awareness work as a first step toward larger institutional research grants. Gulu University and Makerere University are well positioned to formalize this into standing grant relationships rather than one-off workshops.

Multilateral and UN agency partnerships

UNICEF's own experience in Uganda offers a template, not just funding: during the 2022 Ebola response, UNICEF and the Ministry of Health formally trained and equipped traditional healers as frontline risk-communication partners in Kampala, Wakiso, and Mubende districts, treating the roughly 60% of Ugandans who consult traditional healers as an asset to be engaged rather than a problem to be worked around. That same model — formal partnership rather than parallel systems — is exactly what the WHO Global Traditional Medicine Strategy (2025–34) asks member states to build, and it gives Uganda a credible basis to seek WHO and UN-agency co-financing for the pharmacopeia pipeline, not only technical guidance.

9.3 What Government-Led De-Risking Looks Like in Practice

Recruiting this coalition is not a matter of asking each investor type to simply show up. It requires government to build specific, low-cost mechanisms that translate its regulatory leadership into an actual reduction of investor risk:

- **A matching-grant or co-investment fund,** in which a government contribution is released only when it is matched by private, philanthropic, or diaspora capital — multiplying the reach of a limited public budget rather than substituting for private commitment.

[22]East Africa Philanthropy Network (EAPN), organizational description and membership figures (2025/26), describing a membership of more than 200 organizations operating across Kenya, Uganda, Tanzania, and Rwanda.

- **GMP-certification cost-sharing,** subsidizing the cost of bringing a promising small producer up to Good Manufacturing Practice standard, since certification cost is one of the most common reasons a promising formulation never reaches an investable stage.
- **An open-access research facility,** modeled on South Africa's CSIR FuturePharma model, that lowers the fixed cost of laboratory testing for any practitioner, university team, or small investor working on a new formulation.
- **A public early-stage clinical validation fund,** so that the riskiest, earliest phase of testing — the phase no private investor will fund because the odds of failure are highest — is publicly underwritten, leaving private capital to fund the comparatively safer scale-up phase once a formulation clears initial validation.
- **A single public pharmacopeia registry,** giving every category of investor — pharmaceutical partner, diaspora investor, or development bank — one authoritative, government-maintained source of truth about which formulations are validated, at what stage, and under whose intellectual-property protection.

9.4 The Sequencing Argument, Restated

Government first. Not government only.

The case in this section is not in tension with the case in Section 8 — it completes it. Every dollar Uganda's government commits to the research pipeline, the 2019 Act, benefit-sharing law, manufacturing incentives, and raw-material protection is a dollar that makes the next dollar, from whichever source, easier to raise. A diaspora investor, a development bank, a pharmaceutical partner, and a philanthropic foundation are all, in their own way, asking the same question before they commit capital: has government made this sector safe and legal to invest in? Section 8's five investments are how Uganda answers yes. Section 9's coalition is what that yes then makes possible.

10. Building a Sustained Advocacy Campaign

Government funding does not arrive because a need is real — it arrives because someone organizes, asks, and keeps asking. This section sets out why the campaign for African herbal medicine must be treated as a permanent institutional commitment, and how it should be structured to reach from the village to the presidency and, per Section 9, out to the wider circle of investors government leadership can now credibly recruit.

10.1 Why This Is a Lifelong Campaign, Not a Single Ask

Uganda will always need medicine. That fact does not change once the science is done and manufacturing begins — it simply changes what the need looks like. Once African herbal medicine formulations are validated and in production, Uganda still needs continued research to expand the African pharmacopeia, continued regulation to guarantee the safety of every person who uses these products, and continued investment so that this generation's breakthroughs do not quietly die off once the current cohort of herbalists, researchers, and champions moves on.

That is why this paper asks for something more durable than a grant or a single line item: a standing budget line for African herbal medicine research and regulation in every national budget cycle, year after year, protected from being the first thing cut when priorities shift. A campaign built around one appeal wins, at best, one year of funding. A campaign built to reappear at every budget cycle protects the pipeline for the long term.

10.2 The Mining Parallel: Adding Value Before It Leaves Our Hands

Uganda's raw-material problem is not new, and it is not unique to medicine. In mining, the pattern has long been to send raw ore abroad and buy back the finished product at a markup — and mining-dependent countries across Africa are now, belatedly, demanding value addition and clear regulatory terms before the raw material ever leaves the country, precisely the government-first sequencing this paper argues for in Section 9. The Prunus africana case study in Section 4 shows that African herbal medicine follows exactly the same pattern: bark leaves Uganda as an unprocessed raw material and returns as an expensive finished capsule.

In this campaign's case, the raw material is not ore — it is African indigenous knowledge and the African medical knowledge system it belongs to. Adding value means submitting that knowledge to the same rigorous process Western medicine already undergoes: documentation, testing, clinical validation, manufacturing, and scaling — all done at home, before the value leaves Uganda's hands. Framed this way, the campaign is not only a moral or health argument; it is squarely an economic-development argument, with real money to be made in healthcare, and government-anchored investment is what is required to capture it.

10.3 A Multi-Level Stakeholder Strategy

The campaign needs deliberate engagement at every level of government, civil society, and the investor coalition described in Section 9 — not a single appeal to one office. Each level plays a distinct role:

- Community and healer level: The Uganda Herbalists Association, the new Re-Union of Traditional Healers and Herbalists Association, individual practitioners, and faith and community leaders — including the Inter-Religious Council of Uganda — hold the knowledge and the on-the-ground legitimacy that gives the campaign its authenticity and its evidence base.
- District and local government: Building on models such as Masaka District's registration of traditional healers and birth attendants, local governments can pilot integration, generate local data, and create replicable proof points for national policy.
- National ministries and regulators: The Ministry of Health, the National Drug Authority, and the National Council under the 2019 Act are the technical and regulatory home for standardization, licensing, and safety oversight, and need direct, sustained engagement to move implementation forward.
- Parliament and the Ministry of Finance: Because the core ask is a recurring budget line, Parliament's health and budget committees and the Ministry of Finance are essential targets — this is where the campaign must show up at every annual budget cycle, not only when a crisis makes headlines.
- The presidency: Direct executive engagement can unlock funding and political will outside normal ministry channels, as President Museveni's public endorsement of herbalist David Ssenfuka's work already demonstrates — the campaign should treat that precedent as an opening, not a one-off moment.

- Traditional institutions: The Buganda Kingdom's memorandum of understanding with the National Drug Authority shows that cultural institutions can be formal regulatory and trust-building partners, not just symbolic supporters — other kingdoms and chiefdoms are a largely untapped extension of this model.
- Academic and research allies: Gulu University, Makerere University, and the Natural Chemotherapeutics Research Laboratory anchor the credibility of the scientific case and should be visible, named partners at every level of the campaign.
- The investor coalition: Diaspora networks, development finance institutions, pharmaceutical and nutraceutical partners, philanthropic and faith funding networks such as the East Africa Philanthropy Network, and international research-alumni bodies are the audience for Section 9's case, and should be engaged on a parallel, government-led track rather than treated as an afterthought once public funding is secured.
- Continental and international bodies: Aligning Uganda's ask with the WHO Global Traditional Medicine Strategy (2025–34) and comparable African Union initiatives situates domestic advocacy within a wider continental movement and strengthens the case for donor and development-partner support.

10.4 Sustaining Momentum Across Years, Not Just Across Meetings

A campaign this long needs a structure that outlasts any single meeting or symposium. Practical commitments include:

- A standing coalition of faith-based organizations, herbalists' associations, universities, research institutions, and the investor partners named in Section 9, that meets and coordinates outside of symposium season.
- Advocacy timed to Uganda's national budget calendar every year, so the ask for a dedicated line item is renewed before each budget is finalized, not after.
- Public awareness efforts that build political demand for African herbal medicine investment among voters and constituents, not only among officials.
- Ongoing monitoring of implementation of the 2019 Act and related policy commitments, so government can be held accountable to what it has already legislated.
- Deliberate mentorship and funding pathways for young Ugandan scientists and researchers, so the pipeline does not depend on any single generation of champions.

Sustained in this way, the campaign matches the nature of the need it addresses: medicine is never a finished project, and neither is the work of building Uganda's capacity to produce it.

11. Why AFJN Is at This Table

This is a justice question as much as a science question.

The Africa Faith and Justice Network brings a moral voice to advocacy on health equity and African self-reliance. Investing in African herbal medicine is not only about saving foreign exchange — it is about

dignity: valuing the African medical knowledge system on its own terms, as Section 2.3 argues at the level of philosophy, and ensuring the people who hold that knowledge share in what it generates.

Reducing dependence on imported pharmaceuticals and building sustainable, home-grown solutions can create jobs, save lives, and keep resources within our communities — economic development and health justice pursued together, not traded off against each other.

This is self-reliance, not isolation. None of this argues for rejecting modern pharmaceuticals or foreign partnership; Section 9's investor coalition is itself an argument for deeper, fairer partnership with the wider world, not withdrawal from it. It argues for Uganda holding equal footing at the table — producing, regulating, and profiting from its own medicine, the way every established pharmaceutical economy already does, with government leading and everyone else invited to build alongside it.

12. Conclusion: The Call to Invest

We end with one unified question to government, asked first because government must answer it first:

What specific investments will Uganda make in the African pharmacopeia, in district herbal gardens, in Uganda Registration Services Bureau (URSB) registration waivers for healers, and in research grants for young scientists — and what will government do to make that investment the foundation a wider coalition of diaspora, philanthropic, research, and private investors can then build on?

The question is urgent because illness is constant, not seasonal. Somewhere in Uganda, right now, a patient is being treated. The grandmothers in the village whose African indigenous knowledge has never been given a budget deserve to see that knowledge valued, researched, and shared — and to see it defended by a campaign built to last as long as the need for medicine does.

Let us discuss how Gulu University, the Ministry of Health, Uganda's traditional practitioners, and the wider investment coalition described in this paper can build this pipeline together.

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