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## STRENGTHENING HEALTH CARE SYSTEMS: PRIVATE FOR-PROFIT COMPANIES' CORPORATE SOCIAL RESPONSIBILITY ENGAGEMENTS

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### ABSTRACT

This paper contributes to The Post-2015 MDG agenda and the Rio+20 outcome document, *The Future We Want*, by exploring and providing guiding frameworks for how private for-profit companies (PFPCs) can competitively sustain their interests in contributing to the third Sustainable Development Goal (SDG 3), "Ensure healthy lives and promote well-being for all at all ages," through their Corporate Social Responsibility (CSR) activities. A qualitative case methodology rooted in grounded theory was applied to investigate five large companies operating in Uganda. Field visits to CSR projects and semi-structured interviews were conducted with company managers, CSR activity beneficiaries, and health sector stakeholders.

**Key Words:** Health care system, Corporate social responsibility, Sustainable Development Goals, Rio+20

### INTRODUCTION

Globally, efforts to strengthen sustainable health care systems by the World Health Organization (WHO), United Nations (UN) agencies, diplomatic missions, governments, development agencies, academicians, or non-governmental organizations (NGOs) seemed fruitless after the clocking of the January 2015 countdown on the attainment of all, health related Millennium Development Goals (MDGs 4, 5 and 6). The MDGs campaign efforts ran between the year 2000



and 2015 (UN Millennium Declaration, 2000). Unfortunately, by 2015, most efforts recorded mixed outcomes, that is, “off track,” “reversal in progress,” or “close to parity” (*The Millennium Development Goals Report*, 2014; Katamba et al., 2014a). Hope in these specifically health-related efforts has, however, just been restored by culminating the former three health-related goals into one Sustainable Development Goal (SDG) that aims to “ensure healthy lives and promote wellbeing for all at all ages (SDG 3).” The Rio+20 outcome document, *The Future We Want*, mentions that this goal (SDG3) is now the universal set of health care system goals, targets and indicators that UN member states will be expected to use when framing their health care systems’ programs and political strategies over the next 15 years (2015-2030). This period has been branded the “Post-2015 MDG agenda.” The emerging question, therefore, is what will be the fate of the health care system by the year 2030 globally and at the country level? This question surfaces because SDG 3 is one of the current 16 SDGs, a number which is twice the former eight (8) MDGs, of which none of them or even a single target was fully achieved in almost all developing countries (*The Millennium Development Goals Report*, 2014). Furthermore, this question posits that if not creatively and well managed, the current social-economic and political conditions that obstructed the achievement of health care system-related targets will prevail over the current efforts to realize SDG 3.

Corporate social responsibility (CSR) scholars (Visser, 2015, 2008; Katamba, et al., 2014a and b) have mentioned that the above raised concerns could be contained (Philips, 2000; Waddock, 2006; 2004). This is because the current SDG 3 does not seem as ambitious as the former three health-related MDGs (4, 5 and 6) which had six targets altogether pegged on 19 indicators (Katamba et al., 2014a). However, to strengthen the health care system, we need to build on the success stories of the former MDG 2015 agenda (Ki-Moon, 2014), yet at the same time question why some initiatives failed (Inem, 2014). One of the main successes was using PFPCs to engage in this development agenda (*Business Call to Action*, 2013), a move which is largely dubbed, corporate social responsibility (CSR) (Katamba et al., 2012; Porter & Kramer, 2006; Aras & Crowther, 2007; Nkundabanyanga & Okwe, 2011). This makes it important to understand why and how private for-profit companies’ (PFPC) CSR activities can be brought into the equation of strengthening a sound health care system that will ensure “healthy lives and promote wellbeing for all at all ages.” This study will address three research questions (RQs):

- RQ1: What arouses PFPC’s interest to engage in health care system-related CSR activities?
- RQ2: What are the dominant PFPC’s CSR activities and their corresponding contributions to strengthening health care systems?
- RQ3: How can sustainability of these health care system-related CSR activities be ensured?

Uganda (a small developing country and one of the poorest in East Africa) informs this study because (i) it is a signatory to The Rio+20 outcome document, *The Future We Want*, (ii) it is a developing country with unique health care system-related challenges, such as high treatment costs, a poor health infrastructure, and a grappling fiscal budget for the health sector, despite receiving huge amounts from donors (notably USAID) to develop its health system; and (iii) it is in the introductory stages of strategic CSR (Bagire, 2011; Katamba et al., 2012). Health Care Systems (HCS) have been preferred as opposed to other sustainable human development



challenges (poverty, environmental degradation, climate change, food insecurity, etc.), because deriving benefit from efforts mitigating these other challenges can only be beneficial to people who are healthy (Katamba et al., 2014b). This makes SDG 3 central to the post-2015 MDG development agenda and thus requires special attention so as to identify synergies that will yield sustainable results. To inform our RQs and purpose, which is to encourage companies to participate in strengthening health care systems, this research is informed by normative CSR theories, such as stakeholder theory (Freeman, 1984; Barnard, 1938).

Next, we provide a brief review of the literature and explain the study's methodology, before illustrating the findings. We end with a discussion and conclusion. The last sections present policy and managerial recommendations, as well as the limitations of this study and directions for further research.

## LITERATURE REVIEW

### What Is A Health Care System?

According to the World Bank (2007) and Jamison (2006), a health care system is an organization of people, institutions, and resources that delivers health care services to meet human health needs of target populations. This means, a health care system performs functions that include oversight (e.g., policymaking, regulation), health service provision (e.g., clinical services, health promotion), financing, and managing resources (e.g., pharmaceuticals, medical equipment, and information). By this, we can deduce that a health care system is a combination of resources, organization, financing, and management that culminate in the delivery of health services to the population and all activities whose primary purpose is to promote, restore, and maintain health. Inem (2014) has lamented several of the problems facing the health care system in developing countries, including Uganda: (i) differences between urban and rural development and (ii) social economic conditions that escalate the disease burden. Nine combined issues may threaten the achievement of SDG 3, if not addressed. For example, the inverted pyramid structure of health care delivery: 65% to 80% of people live in rural areas, while only about 20% of existing health care is available to them, while on the other hand, 20% of people live in the cities and towns and receive 80% of the medical and health care. In addition, the lack of adequate housing and unhealthy life styles (diet, lack of exercise, smoking, and alcohol use) may seem pleasant to individuals, but they aggravate the prevalence of non-communicable diseases. Furthermore, various country level health schemes are vertical programs (funded or managed by international aid agencies) addressing disease problems like TB, HIV/AIDS, leprosy. They give less attention to health infrastructure development like construction of medical laboratories, labor wards, shaded patient waiting areas, etc. Lastly, relevant generated health care systems data in the early stages of providing improved health services are not utilized in subsequent stages of these programs. This has bred substantial duplication of health care system activities being run alongside similar or related government activities.



## Theoretical Foundations

### (i) *Stakeholder Theory*

In the context of healthcare, AHRQ (2014) defines stakeholders as persons or groups that have a vested interest in clinical related decisions and in the processes that support those decisions. These stakeholders may be patients, caregivers, clinicians, researchers, advocacy groups, professional societies, businesses/PFPCs, and policymakers. Each stakeholder group has a unique interest and valuable perspective on the health care system. Therefore, these stakeholder's interests can be best understood or explained by using stakeholder theory (Freeman, 1984).

Stakeholder theory offers a powerful conceptual apparatus for understanding how PFPCs should organize their strategies in relation to broader societal responsibilities (Carroll, 1991). Stakeholder theory suggests that the needs of shareholders, the primary owners of a business, cannot be met without satisfying, to a reasonable extent, the needs of other stakeholders, such as consumers or local communities (Lantos, 2001). With this in mind, stakeholder theory has become popular for guiding CSR decision-making (Katamba et al., 2014a, b). When developing adequate CSR programs, it thus is important to acknowledge how stakeholders are affected, or can affect, the profit-oriented operations of a business as it pursues its economic (profit-making) agenda. From a 'human' health care systems' perspective, this theory reveals the symbiotic relationship of PFPCs and their wider stakeholders. That is, this stakeholder theory guides how the PFPCs can arrange their own priorities with those of the health care system stakeholders by paying attention to stakeholders' concerns. This includes the need for better health infrastructure, professional doctors, availability of drugs in health centers, etc. (Inem, 2014). This attention is essentially beyond the PFPC's direct profit maximization (Freeman, 2002, 2003; Freeman et al., 2010). Therefore, this theory is fit to guide our study, because even when firms seek to serve their *shareholders* via the primary concern of profit maximization (Carson, 1993; Freidman, 1970), they are likely to be affected by other *stakeholders* whose concerns have to be listened to and addressed.

### (ii) *Corporate Citizenship Theory*

Corporate law considers companies (in this case, PFPCs) as artificial beings. This means they are taken as 'artificial citizens' that should co-exist with other 'human citizens' in the same geographical territory in which they operate. Hence, PFPCs should participate in finding solutions to challenges troubling the local health care systems in the geographical territory. Such behavior reflects basic tenets of corporate citizenship theory (CC) (Carroll, 1991), which is rooted in political science. CC emphasizes the importance of charitable donations and other forms of corporate philanthropy undertaken in the local community (Carroll, 1991). Compared to instances in which corporations engage in charity simply for the sake of it, CC ideally reveals a more organized form of strategic philanthropy (Porter & Kramer, 2006). CC implies giving back to the communities in which a company operates, since this makes the communities better places to live and work, in turn making them better places from which to do business.

Therefore, from the two theoretical foundations above and from what a health care system is and its challenges, we are compelled to ask ourselves:



RQ1: What arouses PFPC's interest in engaging in health care system-related CSR activities?

### **The Concept of Corporate Social Responsibility (CSR)**

CSR is a widely researched subject (Grayson & Hodges, 2004) and its current supportive debates are furthering Bowen's (1953) work. Surprisingly, there is no consensus on what it exactly means. Seminal scholars of this subject (Bowen, 1953; Friedman, 1970; Carroll & Shaban, 2010) and international bodies (World Bank, World Business Council for Sustainable Business – WBCSD, OECD, European Union, UN Global Compact, etc.) have presented numerous definitions of CSR. Broadly understood, CSR encompasses a set of voluntary activities done in pursuance of balancing the economic aspirations of an organization (whether it is profit oriented or not) with its wider community, workplace, and environmental audiences. CSR in the context of a health care system is an umbrella term for those activities done by the organization/company voluntarily, ethically, accountably, and transparently in a way that sustainably contributes to the health and welfare/wellbeing of the societies, communities, and environments in which the organization/company operates or has its reach and influence.

At this moment, this research is interested in investigating what CSR activities contribute towards the wellbeing of health care systems. Henceforth, we pose our research question:

RQ2: What are the dominant PFPC's CSR activities contributing to strengthening health care systems?

### **Sustainability of Health Care System Related CSR activities**

*Sustainability* broadly means an integrated understanding of the interconnectedness of human activity with all related man-made and naturally occurring systems. Precisely, the meaning of sustainability is better understood from the Brundtland Commission (1987) which coined the term, 'sustainable development (SD)'. This commission's report defined sustainability in terms of development initiatives that seek to meet the needs and aspirations of the present society without compromising the ability of future generations to meet their own needs. From this commission, we can deduce that the goal of sustainability is often confronted with the approach needed to attain the goal - sustainable development. Understanding these two terms (sustainability and SD) is an essential first step to addressing a set of global health care systems challenges. Therefore with a focal lens on sustainability of health care systems (HCS), Subramanian, Naimoli, Matsubayashi, and Peters (2011) observed that the approaches to scaling up health services to reach the MDGs were overly simplistic and not working adequately. These scholars observed that it would be better to examine alternative models and approaches which would suggest more sustainable and promising pathways based on what they termed, "learning by doing." That is, through extensive and elaborative engagement of key stakeholders, using data to address HCS constraints, and incorporating results from pilot projects already done elsewhere, though in similar contexts. We henceforth need to know:

RQ3: How can sustainability of these health care system-related CSR activities be ensured?



## METHODOLOGY

### Research Design

Following Burns (1990), a case study research design was appropriate because case studies: (1) are valuable for providing preliminary information to major investigations as they generate rich data from which themes can emerge that warrant further investigation; (2) make “probing deeply and analyzing intensively” (Burns, 1990, p. 366) possible with respect to the numerous occurrences that make up the CSR activities, thus enabling generalizations to the wider population (i.e., Uganda’s private, for-profit sector); (3) may generate anecdotal evidence that can illustrate general findings; (4) are good for disproving existing generalizations; (5) are ideal in scenarios in which pertinent behaviors cannot be manipulated; and (6) may provide the best possible description of a unique historical event, thus providing rich information about PFPCs’ engagement in CSR.

### Selection of Case Companies and Respondents

In selecting the five case study companies, we adopted Katamba et al.’s (2014b) condition that they are (1) companies with recognizable CSR activities, (2) the company must have/had a connection with USAID in supporting health systems in Uganda, and (3) its CSR must have a wide reach and strong presence in rural and/or slum areas of Uganda where the health system is in an alarming state.

### Profiles of Case Companies and Respondents

#### 1. Case Company Profiles

The five case companies studied are: Standard Chartered Bank (SCB), Uganda Baati Ltd. (UBL), Procter and Gamble (P&G), Mabale Growers Tea Factory Ltd. (MGTF) and International Health Hospital Kampala (IHK).

**TABLE 1**  
**Profile of Case Companies**

Company name	Description (year established & core business)	No. of full-time staff	Operations in Uganda
SCB	<ul style="list-style-type: none"> <li>Established in Uganda in 1912</li> <li>Commercial banking services regulated by Bank of Uganda</li> <li>Core businesses in Uganda are consumer banking and wholesale banking (origination, client coverage, and global markets) products/services</li> </ul>	Over 300 staff	Network of 12 branches and 28 ATMs spread across the country
UBL	<ul style="list-style-type: none"> <li>Established in Uganda in 1964</li> <li>Steel-product manufacturing company</li> <li>Subsidiary of SAFAL Group (the largest manufacturer of metal roofing products in Eastern and Central Africa)</li> </ul>	Over 300	Main production line in Kampala (capital city of Uganda); branches in Arua (northern Uganda), Kampala, and Mbale (eastern Uganda)
P&G	<ul style="list-style-type: none"> <li>Established in 1837 and headquartered in the US</li> <li>Manufacturer of consumer goods sold in more than 180 countries through mass merchandisers, grocery stores,</li> </ul>	Approximately 120,000 in approximately	Products are on sale in Uganda, but P&G does not have on-ground



Company name	Description (year established & core business)	No. of full-time staff	Operations in Uganda
	membership club stores, drug stores, department stores, etc. <ul style="list-style-type: none"> <li>Serves approximately 4.8 billion people globally (with brands in more than 180 countries, including Uganda)</li> </ul>	70 countries	operations in Uganda, though it supports CSR initiatives in the country
MGTFI	<ul style="list-style-type: none"> <li>MGTFI was established in 1994 as a transformation from a government parastatal (Uganda Tea Growers Corporation)</li> <li>It is a privately owned, run, and managed smallholder tea factory</li> <li>Since privatization in 1994, MBGTFI has been owned by smallholder tea farmers who supply it with green leaf</li> </ul>	<ul style="list-style-type: none"> <li>3,600 small-hold farmers</li> <li>75 directly employed full-time skilled staff</li> <li>500 general laborers</li> </ul>	<ul style="list-style-type: none"> <li>Located in Kyabaranga Parish, Bugaaki sub-county of Kyenjojo District in Western Uganda</li> <li>Tea is grown in the of Kyenjojo and Kabarole districts</li> </ul>
IHK	<ul style="list-style-type: none"> <li>Private healthcare facility owned by International Medical Group (IMG), the largest private healthcare group in Uganda, comprising health service companies with a regional reputation for customer focus, innovation, and quality patient care</li> </ul>	IHK: over 81	Part of the IMG Group, which has over 40 Medical-center outlets throughout Uganda

Source: Field Data

The case companies cut across five major business sectors in Uganda: manufacturing (UBL), agriculture (MGTFI), banking (SCB), medical and health care (IHK), and household personal care products (P&G). Additionally, each of these companies is a large company (employing over 500 full-time employees), and is among the top tax-payers (paying over 3 billion shillings in total annually; that is, over US\$ 1,500,000). Furthermore, they have been operational in Uganda for over 10 years. Finally, these five companies collectively contribute over 1.2% of Uganda's annual total taxes. Hence, the case selection provides sufficient evidence that they are aware of the needs of Uganda's health system. Additionally, their CSR activities are representative enough to inform policy on health care systems in Uganda, given their GDP contribution.

## 2. Respondents: Managers from These Case Companies

A total of 38 individual managers were interviewed from the case companies. They were of mixed backgrounds and from different management levels, though they largely hold top-management positions (CEOs, Corporate Affairs Directors/Managers, CSR Managers, CSR Program Leaders, Environmental Sustainability Officers, Clinical Officers, District Health Services Officers, General Managers, Project Manager, and Senior Managers responsible for Marketing and Communications).

## 3. Respondents: Beneficiaries from CSR Activities of Case Companies

The direct beneficiaries of the case companies' health-related CSR activities ranged from young children who had received optometry services, antenatal mothers, ophthalmic clinical officers (OCOs), VHT members, and local leaders. Additionally, direct beneficiaries of the CSR activities were interviewed. This mix of respondents helped to re-enforce the findings and data collected.



### Data Collection Procedure

Data was collected following established case study methodological approaches (CAPAM, 2010; McLeod, 2008; Stake, 2005; Yin, 2006, 2008). We analyzed and reviewed CSR reports, memos, and documentaries about the case companies and then interviewed CSR managers and company staff, also interacting with CSR project/activity beneficiaries. This enabled us to elicit views from multiple sources. In particular, following McLeod (2008) and CAPAM (2010), we used a combination of: (1) the learning history approach, i.e., we collectively reflected on the experiences of the interviewed managers by interviewing them to draw constructive lessons using an interview guide. The guide was designed with 'probing questions' which enabled us to analyze CSR activities, events, and episodes from various viewpoints in order to gain insights to inform the study objectives; (2) the best-practice approach (in particular, successful health system-related CSR activities). This emphasizes analysis of documented CSR practices. For instance, we asked P&G to tell us their most important CSR activity that it is engaged in and asked why it was considered worthwhile for transforming Uganda's health care system. Thereafter, (3) we used Yin's (2006) illustrative case study method by providing a descriptive account of the main characteristics of these health systems CSR activities in the business world. Then, (4) we used Yin's (2008) exploratory case study method in order to understand what happened at the individual, community, and country/macro level of analysis as a result of PFPCs engaging in the observed CSR activities. Lastly (5) we employed the explanatory case study method by gathering explanations for why certain CSR activities have been undertaken by the companies studied in particular geographical areas. Throughout, interviews with individual managers of the firms were conducted face-to-face during different CSR training sessions and workshops organized by the research team. The interviews helped us to cross-examine, validate, and build explanations for the information found in the memos/reports/documentaries.

### Data Collection Tools

Data was collected using two sets of structured questionnaires, with interview guides followed for each (that is, one guide for interviews with the CSR teams of the case companies and another for direct beneficiaries of the case companies' CSR engagements (see Appendices B). It is important to note that although we shared these questionnaires with the respondents, in order to avoid receiving biased information, we never shared the guides (in-depth probing questions) with them.

### Reliability

Reliability relates to the consistency with which data is collected. Cronbach's alpha is used in quantitative (calculus based) research methods. However, in qualitative research methods (which this research employed), we cannot easily make these calculations. Thus, we triangulated data, which is the equivalent of reliability testing in quantitative research (Creswell, 2007). We first undertook data source triangulation by considering whether the data gathered would remain unchanged in different contexts. This included the data obtained from interviewing direct beneficiaries of health care systems related CSR projects. That is, children, antenatal mothers, medical doctors, health centers (H/Cs), staff of PFPCs, clinical officers, etc., CSR reports, and actual observation of CSR projects. We studied training reports, CSR project progress reports,



training feedback reports, interviews, observations, and focus group discussions so as to ensure diversity of data similarity.

In gathering the above data from all these respective sources, we employed 'methodological triangulation' by using more than one method to gather data from each source (that is, we undertook interviews, observations, and document reviews). Additionally, we undertook 'investigator triangulation' by examining the same phenomenon independently. Lastly, we engaged in 'theory triangulation' by interpreting the data by different researchers with different viewpoints. This allowed us to extract commonalities that emerged from the results (which formed the basis of our analysis described in the "Data aggregation and Analysis" section below. With regard to data validity, we followed Yin's (2006) guidance at every step (data collection, research design, and analysis) in order to ensure the validity of our findings.

### **Data Aggregation and Analysis**

Since the data we collected related to CSR activities/engagements that feed into health care systems (ICSU-ISSC, 2015), the framework of the third Sustainable Development Goal (SDG 3) provided a rich basis for theme building and aggregation given its clear targets and indicators (see, Appendix A: Details of SDG 3 and its targets by 2030). However, in broader terms, we followed this stepwise process.

We borrowed largely from Charmaz's (1983) 'grounded theory'. That is, we used arrays to display the data, created displays, tabulated the findings (see table in the text hereunder). We then 'ordered' the information as guided by Miles and Huberman (1994). Thereafter, Yin's (2008) 'analytical strategy' was used. That is, 'pattern-matching' (to examine the consistency of themes/segments with literature), 'explanation building', and 'time series analysis', leading us to develop a framework to analyze the data with. For generalization purposes of our findings, we were guided by the 'adaptive theory approach (Layder, 1998). That is, firstly, all the data were analyzed with the purpose of identifying themes, content, and issues. Prior to reaching any theme, content, or issue regarding all the five studied companies, each secondary data source was independently cross-examined. Once all the necessary information was collected, the transcripts and additional information were read and re-read to gain a sense of how each company embraces health care system-related CSR. Most importantly, this was meant to allow diversities to emerge. This process served to identify key issues and provide the opportunity to seek clarifications or additional information. This complete immersion in the data was followed by writing up draft case-studies, which contained facts, interpretation, and links back to the literature, where necessary, and was varied in style, format, length, content, and structure. The transcripts of interviews were then revisited so as to identify issues, concepts, and variables that would bring us closer to answering the research questions. Thereafter, comments, incidents, and repetition were extracted by considering the words and documented actions/attitudes of respondents. The main aim at this point was to produce final case studies that would allow generalizations to emerge in the health care systems.



## FINDINGS AND DISCUSSION

## Interest in Contributing to Health-Related CSR Activities

Interest in contributing to CSR in health issues was largely rooted in: (1) the organizational founders' philosophy (where this was the most prominent driver); (2) top-management involvement and buy-in; (3) the Chairman of the Board; (4) approval from the Board of Directors (BoD); and (5) staff ownership (see Table 2: Interest in contributing to CSR in the health sector)

**TABLE 2**  
**Interest in Contributing To CSR in the Health Sector**

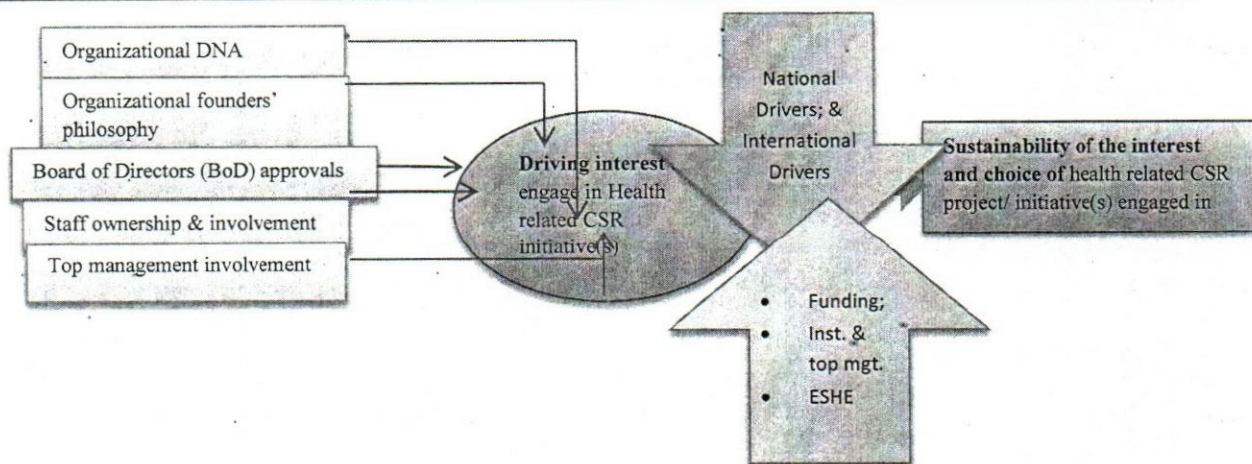
Source	Quotes supporting PFPC's role in CSR	Emerging themes
CSR Mission/ Vision	UBL is actively involved in CSR to an extent that all staff has a DNA of CSR, as well as winning several accolades in CSR. Also, CSR at UBL is driven by the interest of SAFAL Group to see a healthy community within which business is conducted. Lastly, the philosophy and interest of UBL to engage in CSR is deeply rooted in the philanthropic philosophy of UBL's Board chairman (Works Manager, UBL).	Staff buy-in; organizational DNA; organizational founders' philosophy
	In order to give [customers] the best possible leaf, we believe it is important to care for the environment in which tea is grown to protect its vitality [...] We are also committed to the tea farmers and pluckers, whose skill and passion we rely on to select the best leaf. We believe these commitments provide [...] the Mabale tea drinker with a great-tasting, healthy beverage [...]. Mabale's Mission is to become the most profitable smallholder tea factory in Uganda with a vision of having improved standards of living for its small holder tea farmers and the community (Chairman, MGTFL).	Organizational DNA BoD
	[...] IMF was envisioned by Dr. Ian Clarke (founder of IHK and then-CEO). The idea was born out of his experience at 'Hope Ward' and the community appeals for extension of services to vulnerable people that could not afford such expensive health care.	Organizational founders' philosophy
Respondent views	It is the deeds which will be remembered, not the wealth [...]. Similarly, we have a job as industrialists to run our industries well and our mandate is to do good for the community (Board Chairman, UBL).	Organizational founders' philosophy
	[Staff are] all actively involved in CSR. We feel that we should give back something to our society where we are operating. This is a motive of the SAFAL Group to which we belong. Additionally, CSR is one of the major initiatives that have been taken by the group itself and [...] is spread throughout the company (Works Manager, UBL).	Staff ownership and involvement
	CSR is part of our values in the organization. The fact that we have a CSR team and CSR budget annually proves our interest in giving back to the community (HR officer, UBL).	Staff ownership and involvement
	We basically became interested in the CSR projects because there was a need [...] so many people losing sight due to maybe [...] local beliefs that were not helpful, lack of access to health services because they travel from very long distances to reach HCs centres. So because there was a need and because [...] we already committed to supporting the communities where we operate we decided that it would be helpful for us to continue investing in CSR projects. (Ag. Corporate Affairs Manager SCB)	Organizational DNA
	Our farmer representatives attached to those committees have a committee and carry out a needs assessment in their areas. E.g., if they assess that there's a need for a shallow well (to harvest water from), a latrine, classroom block, staff quarters, a community access road, etc. The company will then decide where they can assist. (General Manager, MGTFL).	Organizational DNA; staff ownership and involvement

Source: Field data from FGDs and follow-up interviews



From the findings in Table 2, we can see that stakeholder theory and citizenship theory when applied in understanding CSR in health systems reveals something in common, that is, 'agency'. That is, if health care system stakeholders (already cited in the literature based on stakeholder theory) hold the social license for these companies (who are artificial citizens based on citizenship theory) to operate, we can deduce that a combination of all the five 'drivers of interest' can best be explained using stewardship theory (Donaldson & Davis, 1991, 1993). This is because this theory sees the entire PFPC/sector (that is, the company founder, staff, managers, directors, etc.) collectively as 'stewards/overseers.' That is, they should have an interest in 'overseeing' that the environment in which they operate meets the health care expectations of the 'principal – i.e., the society/stakeholder who granted them social license to operate. Furthermore, PFPCs themselves (as citizens) do not work. However, they work/act through individuals (owners/ directors/ managers, etc.) who represent their (PFPC's) interests. Henceforth, lifting the company veil and looking at these individuals whom we are now viewing as CSR agents of the PFPCs, reveals that each of these individuals contributes in varying degrees to the 'driver of the interest'. At this point, we cannot deny that as these drivers of interest engage in health related CSR activities move towards a particular choice of CSR health care system engagement, they will be affected (positively or negatively). This can be by national drivers (like policy, health development priorities, etc.), International drivers (like global calls for health improvement actions, changes in SDG priorities, development partners priorities, etc.), funding availability, institutional and top management (Inst. & Top Mgt.) level of expertise and commitment, as well as the level of external stakeholder engagement (ESHE).

**FIGURE 1**  
**Framework of Drivers of Interest to Engage in Health-Related CSR Activities**



*Source:* Derived from discussion of findings of drivers of interest to engage in CSR

Note: (1) **Inst. Top Mgt.** = institutionalization & top Management; **ESHE** = external stakeholder engagement. (2) **National Drivers** = cultural tradition, political reform, socio-economic priorities, governance gaps; and crisis responses, market access; **International Drivers** = international standardization, investment incentives, stakeholder activism, supply chain.



### Contribution of PFPC's Towards Health Service Delivery in the Public Sector

After identifying health care system-related CSR engagements (at the workplace and in the community), we ascertained their contributions in terms of any sign of development impact (at national level, community level, or individual beneficiary level) as shown in Table 3. The impact was found to include the number of beneficiaries reached and what positive transformations were observable in terms of improvements in the quality of the beneficiaries' lives in relation to health or the mode of health care delivery.

**TABLE 3**  
**Combined Contribution of Pfpcs' CSR to Uganda's Health Care System**

Case company	Key CSR engagements/initiatives in health	Contribution to Uganda's health system at:		
		Individual beneficiary level	Community level	Country level
<b>1. Standard Chartered Bank (SCB) Ltd</b>	<ul style="list-style-type: none"> <li>- Seeing is believing</li> <li>- Nets for life [Malaria prevention]</li> <li>- Donation of ambulances to Min. Of Health (MoH)</li> <li>- Donation of eye care treatment machines to National and District Referral Hospitals (Gulu, Kamuli, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>- Restoration of sight</li> <li>- Trained specialized eye care workers [Ophthalmic Clinical Officers, OCOs]</li> <li>- Saved lives of pregnant mothers</li> <li>- Improved health conditions of employees</li> </ul>	<ul style="list-style-type: none"> <li>- Support to eye care clinics at health centers</li> <li>- Prevention of blindness</li> <li>- Supported referral hospitals</li> <li>- Created awareness about malaria</li> <li>- Strengthened Church of Uganda's (CoU) efforts to combat malaria</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthened partnerships with gov't agencies health services delivery</li> <li>- Supports to MoH in eye care mgt. &amp; treatment</li> <li>- Supported Health Dev't NGOs (Sight Savers)</li> <li>- Country wide support of malaria prevention</li> <li>- Attainment of SDG3</li> </ul>
<b>2. Uganda Baati Ltd (UBL)</b>	<ul style="list-style-type: none"> <li>- Constructed a health center at company premises (Chandaria Medical Clinic, CMC)</li> <li>- Constructed a patients' waiting shade /shelter at Mpigi H/C 4</li> <li>- Runs health fair promotions</li> </ul>	<ul style="list-style-type: none"> <li>- Enhanced the patients' motivation to wait for treatment at H/C</li> <li>- Increased staff access</li> <li>- Access to ARVs, &amp; HIV/AIDS counseling</li> <li>- Improved health conditions of employees</li> </ul>	<ul style="list-style-type: none"> <li>- CMC provides medical support to neighboring communities, &amp; companies around UBL</li> <li>- The shade/shelter is also used as a training venue, which reduces venue hiring costs.</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthened partnerships with gov't for services delivery</li> <li>- Subsidized access to basic health care</li> <li>- Supported immunization</li> <li>- Contributed to attainment of SDG 3</li> </ul>
<b>3. Procter &amp; Gamble (P&amp;G)</b>	<ul style="list-style-type: none"> <li>- Cleans Safe Drinking Water (CSDW)</li> <li>- Distribution and promotion of W4H physical Kits</li> </ul>	<ul style="list-style-type: none"> <li>- Healthy life style</li> <li>- Motivated women to complete at least 4 ANC visits</li> <li>- 232 service providers trained in using water purifiers</li> </ul>	<ul style="list-style-type: none"> <li>- Improved behavioral change for hygiene and sanitation practices at household level</li> <li>- 95.6% of 227 pregnant women in six districts received and know how to use hygiene kits</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthened partnerships with gov't agencies for services delivery</li> <li>- Strengthened Health Dev't project (STRIDES)</li> <li>- Contributed to attainment of SDG 3</li> <li>- Increased women's delivery at health facilities</li> <li>- Water borne diseases,</li> <li>- Increased IPTp uptake</li> </ul>



	Contribution to Uganda's health system at:			
<b>4. Mabale Growers Tea Factory Ltd</b>	<ul style="list-style-type: none"> <li>- Constructed a health center at the company premises</li> <li>- Constructed a maternity ward at Kigoyera H/C II (awaiting completion)</li> <li>- Constructed pit latrines</li> </ul>	<ul style="list-style-type: none"> <li>- Improved health conditions of employees</li> <li>- Improved hygiene</li> </ul>	<ul style="list-style-type: none"> <li>- Extends health care to over 5000 people in rural areas of Kyenjojo District, relating to HIV/AIDS, STDs, malaria, counseling, SMC, etc.</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthened partnerships with gov't for services delivery</li> <li>- Contributed to attainment of SDG 3</li> </ul>
<b>5. International Hospital Kampala (IHK).</b>	<ul style="list-style-type: none"> <li>- Hope Ward</li> <li>- Crèche</li> <li>- Touch Namuwongo</li> <li>- Yeryotkom (Choose Health)</li> <li>- Track TB</li> <li>- TB diagnostic research</li> </ul>	<ul style="list-style-type: none"> <li>- Improved health conditions of employees</li> <li>- Trained VHTs</li> <li>- Enhanced patient home care (an equivalent to palliative care)</li> </ul>	<ul style="list-style-type: none"> <li>- Youth engagement in health promotions</li> <li>- Reduced TB &amp; HIV related mortality &amp; morbidity for 66,530 urban slum dwellers in Kampala district</li> </ul>	<ul style="list-style-type: none"> <li>- Provision of clinical/ diagnostic research data</li> <li>- Contributed to attainment of SDG 3</li> </ul>

Source: Compressed from interview scripts, field visits, CSR reports, & non participant observations

From Table 3, we note a wide array of CSR engagements: edutainment, palliative care, counseling, water and sanitation, immunizations, prevention of mother to child transmission (PMTCT) of HIV/AIDS, antenatal care, and home-based care, etc. All of these CSR engagements were found to be multi-faceted, but all directed to company spheres of influence notably: (1) CSR in the workplace; (2) CSR in the community neighboring the company; and (3) CSR in communities not located in the company's immediate community.

This bevy of CSR engagements and their numerous resultant contributions to Uganda's health systems supports Visser's (2008) suggestion that there is a large range of CSR engagements in developing countries. However, the fact that we found mixed contributions suggested a need to assess the extent of each CSR activity's impact. Therefore, the CSR engagements that are 'pure philanthropic' in nature (such as donating ambulances or W4H hygiene kits) seem to have made good contributions to health systems development – as supported by several scholars (Porter and Kramer, 2002; Visser, 2015). However, a critical look into the needs of the Uganda's health system suggests that the contribution of 'philanthropic' CSR engagements is slightly lower compared to engagements that are strategic in nature (e.g., construction of and equipping health centers with needed facilities such as MGTF's HC, the maternity ward at Kigoyera Health Center II in the Kyejonjo District, etc.). This is because these 'strategic philanthropic' engagements if given more attention would make a broad contribution to Uganda's health care system. That is, they serve many patients/beneficiaries at once and would offer a breadth of services to beneficiaries, such as laboratory, immunization clinics, admission, ANC facilities, etc. This research further noted that these 'strategic philanthropic' CSR engagements were not linked to the core business of the engaging companies. For example, SCB engages in communities in which it does not have a business presence and in remote districts (such as Kamuli, Kaliro, Gulu, etc.) with its 'seeing is believing', 'nets for life,' etc. However, these CSR activities were found to have made a big contribution to all the three levels (see Table 3 columns under, 'Contribution to Uganda's health system'). This finding challenges some scholars, notably Porter and Kramer (2003), who argue that it is mainly CSR engagements that are aligned with core businesses that yield the biggest contributions/benefits and competitiveness since they align well with the business's /organization's core competencies.



Finally, P&G provided a relatively unique perspective in the discussion of CSR engagements in health. That is, although it has no physical presence (like established office representations/branches) in Uganda beyond its product sales (like Pampers, Always sanitary pads, etc.), Uganda has benefitted from its global hygiene and sanitation project for children (Clean Safe Drinking Water, - CSDW). This finding therefore suggests a need to revisit the concept of 'sphere of influence,' (Grayson & Hodges, 2004) in the sense of redefining what should actually be included in this sphere and what parameters should be used to describe it.

*Sustainability of health-related CSR activities:*

We found that sustainability is ensured through: (1) funding; (2) institutionalization and top-management engagement; and (3) external stakeholder engagement. These findings are detailed below.

### **(1) Funding**

This involved ascertaining how financial contribution is guaranteed with respect to the choice of CSR engagement, as well as towards ensuring that the PFPC lives by the promise of what drives it to engage in CSR. The funding aspect involves: (i) beneficiary contributions; (ii) company contributions; (iii) income-generating activities; (iv) government support; and (v) fundraising drives. These are detailed below:

#### **(a) Beneficiary Contributions**

Both staff and the general community contribute a small fee, which is subsidized by the company:

[...] We have distributed mosquito nets to our staff and [...] the community [...] we don't only cater for our employees but we are mindful to the community that is around us. To the community the mosquito nets were given at half the price [or] at a discount, so that was showing CSR to the neighboring communities. (HR Officer, UBL)

[...] The community pays a user fee of UGX 2000= (approx. USD 0.8), for every visit to the clinic, but the drugs are free. Other services offered by the clinic are antenatal care, postnatal care, HIV/AIDS Counseling and Testing [HCT], static and outreach immunization plus safe male circumcision. We treat and also refer clients to other higher health centers or district hospital[s]. (Clinical Officer, MGTFL Clinic)

[...] 83% of funding for Hope Ward (at IHK) comes from corporate sponsors [...] and 1% is received from patient contributions. (Executive Director, IMF)

#### **(b) Company Contributions**

We investigated whether companies have a specific budget allocated to sustaining CSR activities. We found that:



4. [...] P&G has a standing global budget of over USD 50 million to sustain its CSR interests and activities: "from the start of the CSDW [children's safe drinking water program] program in 2004 to date, the Ballpark estimate of CSR investment in Uganda through CSDW is more than USD \$3 million, which gives an annual investment of USD 300,000." (Program Leader, CSDW, P&G)
5. [...] UBL has a standing percentage that is annually budgeted to cater for CSR activities: "We normally keep a budget of 1-2% of our annual turnover as a CSR project, and then that project is [fed] into other CSR projects." (Works Manager, UBL)

At MGTFI, it was revealed that on top of fair-trade premium sales (which are not sufficient to sustain CSR initiatives) the company makes an annual contribution of over UGX 250 million:

6. [...] We have the premium sales which are 100% for CSR. But in our individual budgets, we have a total of about 15% allocated for CSR activities. That is to say, a portion goes to health, environment, field extension initiatives, leaf shade construction and pit latrines. The percentage is high because the areas we work with are difficult to differentiate from other activities. They are all integrated. (General Manager, MGTFI)
7. [...] In total, IHK/IMF annually allocates over UGX 1.7 billion shillings (approx. US \$600,000) to CSR and much of the money goes [towards buying] drugs for patients. (Executive Director, IMG)

#### **(c) Income-Generating Activities**

We found that some companies dedicated all proceeds of certain initiatives directly to fund CSR activities.

[...] MGTFI in 1997 joined the Fair Trade movement (a system where a certain percentage of sales revenue earned in the fair trade circuit is reinvested in collective economic and social projects that enhance the quality of life). All the funds [...] from Fair Trade sales (which average 2-5% annual tea sales), is 100% allocated annually to CSR activities. These sales fetched over [UGX] 27 million shillings in 2013. (Environmental Officer, MGTFI)

[...] We sell our products as Fair Trade products on the tea auction market in Mombasa and [in] 2013 we fetched over UGX 27 million (US\$ 9,000). There's a premium attached to the sales and with our involvement [in] the fair trade movement, we are able to get an extra dollar on what is sold. The premium generated is [...] used to start off CSR activities. We are not limited to health-related activities, but also engage in education, where we have constructed classroom blocks for [various schools], and accommodation for our staff, etc. (General Manager, MGTFI)

#### **(d) Government Support**

The government was found to have played a role in sustaining the interest of PFPCs to engage in health-related CSR. This has been either through direct financial support to companies or



through local governments (LG). However, support through LGs was typical of CSR activities in rural areas and direct central government typical of urban engagements:

[...] The GoU [Government of Uganda] through the Kyenjojo District Local Government administration financially supports the clinic monthly and also in-kind by giving it assorted drugs, (Clinical Officer, MTGFL Clinic); When the district realized that we had put up a clinic, they partnered with us and provide 300,000 UGX every month to supplement our budget. (General Manager, MGTFL)

#### **(e) Fundraising Drives**

This involved persuading fellow corporate companies for sponsorship, external funding through writing grants applications, etc.

[...] Seeking external funds has been embraced to sustain CSR engagements in health at IHK through its IMF, by writing proposals and submit[ting] them to donor agencies like USAID, DFID, etc. [...] in 2013, we concentrated on developing proposals and partnerships and two projects came on board, one for Kampala and the other for Lira. Other proposals did not go through; the feedback we got was general so we couldn't figure out what the problem was. (Executive Director, IMF)

[...] 83% of funding for Hope Ward (at IHK) comes from corporate sponsors, 16% of the funds come from fundraising, and the remaining 1% is received from patient contributions. Corporate sponsors of Hope Ward include companies and NGOs (IAA Healthcare, Stanbic Bank, Narrow road, Mvuule trust, and Bead for life, among others). (Executive Director, IMF)

### **(2) Institutionalization and Top-Management Engagement**

The PFPCs studied had CSR governance mechanisms in place, including (i) independence; (ii) continuity; and (iii) outstanding CSR interventions. A combination of these revealed that when CSR ideas/interests are realized in these organizations, they are transformed or have to be taken on as an organizational issue (that is, 'institutionalized'), and top management has to engage in them to see their success. The events outlined in the quotes below justify this governance mechanism:

[...] Dr. Ian Clarke's (the founder of IHK/IMG) vision of the Hope Ward, and all the other CSR interventions of the IMG, was later transformed into an organization (IMF), which was registered as an NGO in Uganda in 2005. A fully fledged team of IMF staff who man the CSR ventures/engagements was 'instituted'. A 'vision' [A healthy community full of hope and with access to quality healthcare] for IMF and a mission were framed and an 'Executive Director' [Mrs. Annet Kobusingye Sessanga] appointed, as well as line managers below her, to lead the strategic direction of IMF. Work plans and targets are set forth [and] annual and periodic reports are produced. These have served as a means of communication about updates to the IMG group to inform future decisions for sustainability purposes. (Executive Director, IMG)



[...] To accelerate members' interest in CSR, MGTFL set up a 'premium committee'. This committee is responsible for all the CSR interventions. It is audited at the end of the year. It has to declare all sources of money to finance CSR activities, including reporting how it used Fair Trade premium[s] to finance its CSR engagement. (Managing Director/CEO, MGTFL)

### **(3) External Stakeholder Engagement (ESHE)**

#### **(a) Means of External Stakeholder Engagement (ESHE)**

The primary means of ESHE were found to include: CSR annual calendars, report sharing, meetings, and feedback sessions. Meetings and feedback sessions were found not to have fixed schedules and CSR calendars (schedules of CSR activities) were found to be produced annually. In all types of engagement, the target community and/or beneficiaries for the CSR activity were found to be well known by the engaging company. Additionally, respondents mentioned that these engagement means offered an opportunity to clearly inform and demonstrate to the various stakeholders (police, neighboring communities, employees, industry associations, etc.) what CSR activities should be conducted, at what cost, and when.

[...] We have also been working with government agencies like Uganda Investment Authority, had a health fair in Namanve industrial park, and we contributed to some of the components like medicines to make sure we partner in a meaningful way. Additionally, we are in touch with KCCA [Kampala Capital City Authority] [who] have launched the 'Green Kampala campaign' and we want to partner with them to see how we can support them in terms of any material[s] or support. Talks are going on [and] we have not yet concluded, but I hope we will work them as health partners. (Works Manager, UBL)

[...] For any CSR engagement, we start with the communities then we work with the partners who are reaching them and then we of course include government relationship[s], government stakeholders, [...] so it's a pretty strong program and it's been in place for 10 years so we look carefully to see where we are needed and where can we give the support and help. (Program Leader, CSDW, P&G)

#### **(b) Stakeholders Engaged**

These included: religious leaders; financing institutions/ banks; the GoU's Ministry of Health (MoH); development agencies (e.g., USAID, UK Aid, etc.); corporate companies; local leaders/councils; industry associations especially Uganda Manufacturer's Association (MA); fellow companies around UBL; and police.

[...] Last week we participated in another health fair with Kiswa Health Center. Kiswa is a community around Bugolobi (our neighborhood), and it's served [by our Health Center, *Chandaria Medical Clinic*]. So we also carried out [a] health fair in this neighborhood [for] all components including HIV testing, circumcision, etc. (HR Manager/CSR Team Leader, UBL)



[...] We partner with the national referral hospitals and other approved health centers [...] and [the MoH] of course because we use their structures we cannot even say that it is just us (SCB) and Sight Savers International, it is also ministry's responsibility. We use the national infrastructure to implement this project. (Child Eye Health Project Coordinator, Sight Savers International)

Pegging the concept of sustainability (Brundtland Commission, 1987) to these findings, we can be convinced that with a collection of these themes/factors (funding, external stakeholder engagements, PFPC's top management engagement and involvement, etc.) a health care system mounted on sound CSR engagement will be sustainable. This is because the findings seem to cut across a broader array of what it takes to sustain CSR engagements (like finances, which is a back born sustaining many business related decisions (KPMG, 2008; Kakuru, 2007), stakeholder engagement (Lantos, 2001; Freeman, 2002, 2003; Freeman et al., 2010), and institutionalization (ISO 26000) in health care systems. However, we might be misled and lose such valuable CSR engagement if we took the issue of their sustainability just from the surface (of these sustainability themes) as opposed to making an in-depth balance with views of CSR critics (Friedman, 1970; Carson, 1993). This is because these critics are indispensable when discussing solutions to sustaining a sound health care system founded on CSR, since the primary reason for setting up PFPCs is profit maximization. Therefore, to valuably counter these critics, the engaging company has to ensure that attention and promotion of details under each sustainability theme is maximized. For example, as can be seen from figure 2 below, under: (i) 'funding,' there is beneficiary nominal contribution. If this is pursued, it will not only ensure basic sustainability, but also promote ownership of the CSR supported health initiative by the beneficiary by way of the beneficiary making use of the facility/donation (e.g., a mosquito net being used by a pregnant mother; drugs being swallowed by a patient; etc.). (ii) Under *ESHE*, there is engagement of Ministry of Health. Given the limited central governments' support of public health entities, engaging these entities makes them feel complimented in their health provision mandate, yet budget-waived, henceforth, finding a reason to sustain the CSR health initiatives. This will in fact help to reduce the constraint of health activity duplications observed in the literature by Inem (2014). Lastly, (iii) establishing a strategic fit between CSR activities and the case companies' core business (as advised by Porter & Kramer, 2002, 2006). This will result in a PFPCs' interest in health care system CSR engagement be translated into tangible actions (CSR projects/initiatives) as shown in Figure 2.

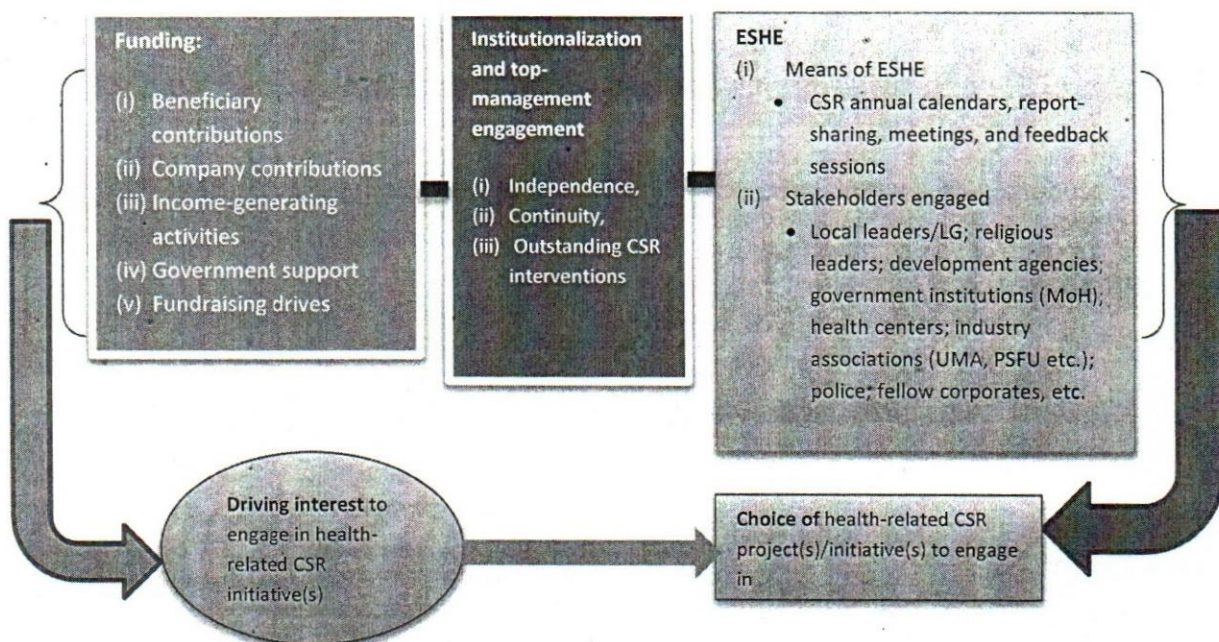
## CONCLUSIONS

CSR engagement of PFPCs can contribute to the betterment of a health care system. However, their interest in engaging in CSR, as well as how to ensure sustainability of this engagement forms the backbone upon which the choice of any CSR engagement will be made. However, funding mechanisms, as well as which stakeholders to engage, are crucial aspects that also determine the success and sustainability of health care system CSR engagements. This study found that a variety of CSR activities have been conducted by individual companies on an aggregate (country and community) level and individual level and these have benefited individuals, communities, and the country at large. The conclusion here is that well-coordinated and strategic philanthropic CSR engagements in health can indeed contribute greatly to the realization of SDG 3 and its resultant targets. Lastly, the studied companies alone, irrespective of



their combined contribution of 1.2% to Uganda's annual collected taxes, cannot make enough impact on the macro picture of a better [Uganda] health care system. This means that steps have to be taken either by government, development partners, UN agencies, NGOs, and CSOs to encourage other private companies to engage in health care system-related CSR initiatives. This encouragement may be by way of undertaking back and forth dialogue and consultations, as well as assuring support.

**FIGURE 2**  
**Framework for Sustainability of Organizational Interest to Engage in CSR**



Source: Author's own elaboration

### Managerial Recommendations

8. Managers of PFPCs elsewhere in the world should try to make use of the frameworks suggested in this research to improve their CSR engagements in health and also to replicate them to other CSR engagements like poverty reduction, environmental sustainability, etc.
9. For other companies (especially very large ones), the research suggests that CSR can be replicated. Thus, we recommend that partnerships be formed between private-sector companies with health care priority driven agencies so that they can jointly pursue health care system-related initiatives.

### Policy Recommendations

10. A mechanism could be instituted to reward and encourage role-model PFPCs that have contributed to health care systems through CSR.



11. A policy could be put in place to guide CSR interventions in health care systems and provide information to interested PFP companies.
12. A CSR PPP could be created in countries where it is currently non-existent.

### Limitations and Directions for Further Research

13. The study is cross-sectional in nature. Thus, it may have missed gathering results that enable us to capture longitudinal perspectives of a 'developing' health care system over time. Therefore, we recommend that longitudinal studies in the same or modified line of thought be undertaken so as to establish a pattern of CSR engagements with respect to the changing needs of the health sectors of respective countries.
14. The sampled companies are very large, which may limit replicability of the findings and recommendations with respect to PFPCs which are small and medium-sized (SME) in nature. We therefore recommend that a similar study be conducted focusing on SMEs, because these form the largest portion of Uganda's (developing countries) economy. This would provide good comparative results that can further inform policy.
15. While care was taken to control for quality (utility) and also to ensure the reliability and validity of the research findings, the qualitative nature of the research design adopted does not provide room for statistical verification of the frameworks that emerged from this study. We recommend conducting a quantitative study that can verify the significance and strength of the relationships noted, as well as predict the potential of these relationships and the variables that emerged from the themes contained in the frameworks.

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### APPENDIX A

#### Details of Sdg 3 and its Targets by 2030

GOAL /TARGET	Applicable	Implementable	Transformative	Overall for goal 1
<b>SDG 3: Ensure healthy lives and promote well-being for all at all ages</b>	<b>1.0</b>	<b>1.7</b>	<b>0.7</b>	<b>1.5</b>
3.1 by 2030 reduce the global maternal mortality ratio to less than 70 per 100,000 live births	0.0	2.0	0.3	0.0
3.2 by 2030 end preventable deaths of new-borns and under-five children	1.0	1.7	0.3	0.7
3.3 by 2030 end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases	1.0	1.7	0.3	0.7
3.4 by 2030 reduce by one-third pre-mature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing	1.3	1.7	1.0	2.3
3.5 strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	2.0	2.0	1.0	4.0
3.6 by 2020 halve global deaths and injuries from road traffic accidents	1.7	1.7	1.0	2.7
3.7 by 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	0.0	1.7	0.3	0.0
3.8 achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all	0.3	2.0	0.3	0.0
3.9 by 2030 substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination	1.3	1.3	1.7	3.0

Source: Universal Sustainable Development Goals (SDG): Understanding the Transformational Challenge for Developed Countries, Report of a Study by Stakeholder Forum, May 2015 (Pg. 13),

<https://sustainabledevelopment.un.org/content/documents/1684SF - SDG Universality Report - May 2015.pdf>

NB: 'A Goal' that is considered to be achieved in the context of a developed country would be scored, just like, "a target" that is considered highly relevant and transformative for developed countries, but potentially challenging to achieve and in this case would be scored as follows: Applicability (0); Implementability (2); Transformationalism (0); Overall Score (0)

### APPENDIX B

#### Questionnaire/Interview Guides

Respondent consent seeking (for every person participating in this research:

	Tick here
I confirm that I have been informed of the nature/purpose of research and have the opportunity to ask questions	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason	
I fully agree to take part in the interview under the terms above	



RQn 1: Arousing interest to engage in CSR

1. How would you describe your organization/business?
  - Probe for Number of full time staff; its business nature (agriculture, service, etc.)
2. What does the term 'corporate social responsibility' (CSR) mean to you, and to the organization?
  - Probe to assess whether generally CSR is built into the mission/vision of the business/organization
3. How did your organization/company come to get interested in health related CSR activities?
  - Probe for how CSR in health started? why? What drives/drove this spirit/interest to engage in CSR in health? How do they plan to keep the interest?

RQn 2: Dominant PFPCs CSR activities and their corresponding contribution

1. How does your business make decisions on what CSR activities/practices/programs to be engaged in?
  - [Probe for any stakeholder engagement in those decisions, and the extent to which the decisions relate to PR/strategic CSR]
2. What types of CSR activities/practices are engaged in by your organization?
  - [Probe for the nature of these programs]
3. Which CSR activities/practices are most significant for your company?
  - [Probe to see where health-related programs stand]
4. Do your company's CSR programs contribute towards health-service delivery in the public sector?
  - [Probe for how (if yes) or why not (if no)]
5. Does your organization support (either financially or in kind) any health-sector initiatives/programs related to meeting community needs?
  - [Probe for how (if yes) or why not (if no)] Probe for 'How sustainable'

RQn 3: Sustainability of CSR engagements in health systems:

From your experience, what needs to be done in order to sustain benefits from, and engagements in health-related CSR activities / Practices?

- Probe for any background work, who needs to be involved, etc.
- Probe for any steps required such as setting **goal of your CSR initiative, core values driving the initiative; stakeholder engagement; capacity/ financial muscle; actions and behaviours that will lead to sustaining the outcomes; Creating a pilot project, etc..**

Beneficiaries Interview Questions:

1. How familiar is company X (mention the respective company name) to you?
  - *[This question is asked to see if the respondent/beneficiary, can connect company X, to its CSR activity] if he/she cannot, then help her/him to focus the discussion on CSR of the investigated company.*
2. Has everyone heard of Company X's CSR activity—*[Please mention a specific CSR, which the company talked about, DO NOT mention many programs/activities at ago]*? How have you personally and people of this community, benefited from that activity?
3. How long have you been benefited from Company X's activity?
4. What are some things that aren't so good about Company X's CSR program you mentioned?
5. How has Company X's activity contributed towards the improvement of health service delivery in your village/town/region?
6. What would be some of the likely problems to your health 'system' if Company X's activity stops?
7. How can Company X and may be other companies continue sponsoring/engaging themselves with projects such as Company X's activity?



