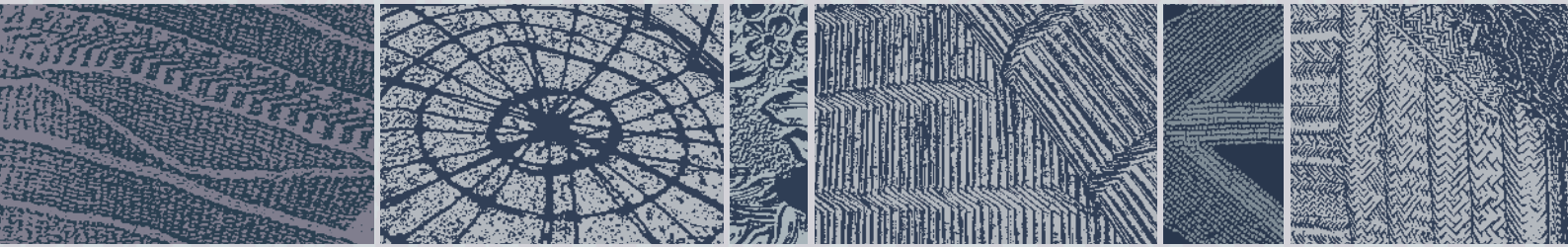


CHAPTER 6

CASE-STUDY UGANDA



THE CONTRIBUTION OF RELIGIOUS ENTITIES
TO HEALTH IN SUB-SAHARAN AFRICA

CHAPTER 6

6.1 INTRODUCTION

This chapter begins with an overview of the health system in Uganda and the forces that have shaped it, indicating the role of the faith-based sector in this context. It describes the contribution religious groups make to public health, provides an indication of the capacity of health-supporting REs, their sources of financial and material support, collaboration and networking in the sector and with other actors, and outlines some common perceptions of the sector by various stakeholders. It concludes with sections on the constraints for REs in their endeavour to work for better health, considerations on how they can be supported in this endeavour, and makes some recommendations.

6.2 OVERVIEW

6.2.1 HISTORICAL CONTEXT

Protestant and Catholic missionaries settled in Uganda in around 1890. The country remained under British control until it gained independence in 1962. The new Ministry of Health inherited several hospital facilities, some run by mission agencies. In the period from independence to 1971, Uganda was reported as having the best health care system in the sub-region.¹

In the 1970s, divisions in the country led to ongoing strife. During this period of turmoil, there was little investment in health care and facilities became run-down. Other than faith-based organisations, many health-providing NGOs ceased to operate. Several key informants in this study confirmed the importance of mission hospitals in the early colonial period and during times of turmoil in later years.

A new phase began with the coming to power of the National Resistance Movement led by President Museveni in 1986,² when considerable investment was focussed on political and economic preconditions for growth. During this period, the national government's investment in health was very limited, with some ad-hoc investment made in hospital facilities.³ In the late 1980s and early 1990s, in the absence of a national health plan, multiple donors set up vertical health programmes⁴ and UNICEF became known as the 'alternative' Ministry of Health.⁵

6.2.2 SOCIO-DEMOGRAPHIC FEATURES

In 2007, Uganda's population stood at almost 31 million people, over half of whom were under 15 years of age.⁶ Figures from the mid-2000s indicated that only two thirds of those over 15 years of age were literate.⁷ Eighty-five percent of the population were Christian (half of which were Catholic and half Protestant, of which Anglicans were the largest group) and 12% were Muslim.⁸

Despite the considerable international aid focused on economic performance after the war, Uganda remained one of the world's poorest countries: it is ranked 145 of 177 in terms of the Human Development Index of 2006.⁹ The proportion of the population in poverty fell from 56% in 1992 to 34% in 2000, in part due to economic growth of 6% per annum in the period 1990-2006.¹⁰ However, there was a parallel increase in income inequalities during this period,¹¹ with Gini Coefficients shifting from 0.35 to 0.45 in the period from 1992-2003.¹² The high proportion of the population still in poverty could be attributed to the slow pace of rural development and poverty reduction, in a context where the majority of the population was rural and agriculture contributed about a third of the GDP. Other contributing factors included high rates of HIV and AIDS, slow private-sector development, ongoing political instability in the north, heavy reliance on international aid and weak institutional and human capacity.

1 Enable 2006.

2 World Bank 2005.

3 Enable 2006.

4 See Chap 3.2.5 about the trend toward 'diagonal support'.

5 Enable 2006.

6 Mayanja 2005.

7 Kintu *et al.* 2005.

8 US State Department 2007.

9 World Bank 2005.

10 World Bank 2005.

11 World Bank 2005.

12 Ugandan Ministry of Finance, 2004 in Okunzi 2004.

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6.2.3 BURDEN OF DISEASE

The key health problems in the country were HIV and AIDS, malaria, TB and a number of other typical infectious diseases.¹³ These were compounded by high rates of malnutrition.¹⁴ Furthermore, inferior maternal and perinatal conditions added considerably to the workload of health centres; their inability to respond adequately resulted in an unacceptably high maternal mortality rate in Uganda.¹⁵

6.2.4 THE HEALTH SYSTEM

Health Sector reform was introduced in Uganda in 1994, based on principles laid out by the World Bank. Reform was a precondition for countries to be able to access external aid. Many held the view that these reforms not only failed to improve health services but were also instrumental in undermining the health system.¹⁶

The decentralisation strategy of this period has been interpreted by some as an excuse for central government to abdicate its responsibility in health service provision. Further, although considerable financial resources were made available by international donors to support this strategy, this often did not result in the anticipated improvements, as the donors and the MoH earmarked the funds for specific uses.¹⁷

In line with the underlying principles of the reform, user fees were introduced in the early 1990s (again as a condition of receipt of a World Bank loan)¹⁸. However, user fees only managed to offset 5% of costs and did not lead to improvements in health services or health outcomes, as many people were deterred from using the health system. This, together with political factors, led to the decision to end user fees at public health facilities in 2001.

Around the same time, a Health Sector Plan and National Minimum Health Package were adopted to ensure allocation of funds to priority health problems on an equitable basis.¹⁹ Over 50% of Uganda's health funding remained sourced from international aid in 2004²⁰ and a health sector-wide approach (SWAp) was adopted "to improve health status and services through a coordination of resources". A national social health insurance scheme was to commence in January 2009.

Nonetheless, Uganda's health system remained chronically under-funded, with only US \$5 per capita being spent by the government in 2006, with an additional US \$3 being received from the donor community. This was considerably lower than the US \$34 per capita suggested by the Commission for Macroeconomics and Health. Only a third of the budget went to primary facilities, while over half was invested in secondary and tertiary facilities.²¹

In 2007, a number of shortfalls in the health system in Uganda were highlighted in a report by the Auditor General, which noted that "hospitals and other frontline health centres were ... systematically failing to provide adequate services to patients".²² Often equipment was poorly maintained, there were insufficient staff and drugs (especially in rural areas) and there was evidence of some corruption.

6.2.5 THE ROLE OF RELIGIOUS HEALTH SERVICES

In Uganda the private sector was understood to include traditional healers, non-governmental organisations (NGOs) (including FBOs) and private health care providers. The term 'private-not-for-profit' (PNFP) was used for organisations guided by the concern for welfare of the population rather than profit. The majority of such organisations were founded by religious bodies, to the extent that the term, loosely applied, was almost synonymous with the Ugandan religious health sector, although it strictly included secular groups that provided a minority of PNFP services. Henceforth this chapter refers to the religious sector as PNFPs, as is common in the country.

13 WHO 2007.

14 PL.doc - 17:3 (9:9).

15 PL.doc - 17:40 (72:72). In 2000 the maternal mortality rate was 880 per 100000 live births (WHO Afro 2006).

16 Okuonzi BMJ 2004.

17 Okuonzi 2004.

18 Okuonzi 2004.

19 Mayanja R. 2005.

20 Okuonzi 2004.

21 Enable 2006.

22 plusnews 2007.

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PNFPs were seen as especially important given their responsibility for around one third²³ of service provision (17% of all out-patient consultations, 35% of all deliveries and 29% of all DPT3 immunisation doses, according to a 2007 report).²⁴ The Health Sector Strategic Plan identified the importance of strengthening partnerships with the private sector, given its extensive role. Indeed, the reforms of the early 1990s had already identified the private sector and NGOs as key providers of health and social services. The National Health Plan did not distinguish between public facilities and PNFPs and its guidelines applied to both.²⁵ Traditional healers (TH) also played an important role in providing primary health services to about 60% of the population.²⁶

6.3 CAPACITY OF PNFPs IN UGANDA TO PROVIDE HEALTH SERVICES

6.3.1 HEALTH SERVICES

Most agencies surveyed by this study, with respect to facility-based services, as well as the focus groups, reported that they provided hospital or general health services. Of the 18 agencies interviewed, six were Muslim, seven Catholic and the balance from Protestant churches. All of them were affiliated to one of the three faith-based medical bureaus (see 6.3.2).²⁷

The health services provided by the agencies were predominantly community-based, primary and secondary health services, although three included tertiary hospitals. Many of the agencies reported serving large numbers of outpatients monthly (that is, over 10 000 outpatients, with some having as many as 17 000 outpatients), although some were much smaller in scale, serving 60 outpatients a month. Over two thirds offered dispensary services and these provided for a range of between 100 and 20 000 patients per month. While a few of the facilities provided inpatient care to fewer than 100 patients a month, several were much larger in scale, with between 500 and 3 000 patients on a monthly basis.²⁸

Key informants also commented on the wide range of curative, preventive and promotive services provided by PNFP facilities.²⁹ These included “everything that it takes to be a private hospital”, in addition to training institutions and outreach services.³⁰ Clearly then, PNFPs provided an impressive range of health services that were similar to and sometimes went beyond those of the MoH.

Box 6.1 Does “working for God” matter?

An independent survey found that PNFPs in Uganda provided similar services to those of the public sector in terms of inpatient care, laboratory services and immunisation, but were more likely than their public counterparts to provide outreach, health education, antenatal care and training of nurses and community health workers – services with a strong public good component.

(Reinikka & Svensson 2003.)

MNCR: Many of the surveyed agencies reported that they specifically targeted women, children under 5 years, as well as youth living in rural areas. Two specifically mentioned services for pregnant women.³¹ Maternal health was a serious concern for health providers in Uganda; accordingly a number of PNFP facilities had reduced user fees that applied to this group to make their services more accessible.

When asked what additional services they would like to provide in future, agencies identified the following:

- higher level specialist services
- diagnostic equipment (such as scans, ultra-sound)
- better laboratories
- cancer treatment, and ear, nose, throat, dental and eye care
- improved services to rural areas (especially with respect to ambulance services and deliveries), and
- more antiretroviral treatment (ART) and prevention of mother-to-child transmission (PMTCT).³²

23 MoH.doc - 19:2 (16:16).

24 UCMB 2007.

25 UNICEF.doc- 15:10 (22:22)

26 ROU 2006.

27 Questionnaire data.

28 Questionnaire data.

29 WHO.doc – 14:6 (57:57)

30 UMMB.doc - 21:24 (73:73).

31 Questionnaire data.

32 Questionnaire data.

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Managers of health facilities were aware of the challenges around scaling up ART, especially at a time where the sustainability of services was already in question. However, they found it difficult to resist the public pressure to enrol more people on ART, and were attracted by the prospect of an additional allowance for managers of such services made available by funding agencies.³³

A number of existing resources were identified as providing a platform on which to expand services, including the skill and commitment of staff and the considerable infrastructure in the form of existing buildings. The key limiting factor was funding, for equipment (including maintenance), remodelled and new buildings, and the training of new personnel and supervision.³⁴

Regarding **non-facility-based health services**, PNFPs provided a range of services in support of the work they did through their health facilities. These health-supporting initiatives added another dimension to the holistic package of services to improve community well-being. Accessing data on these services was difficult, however, as they often lacked co-ordinating structures and proper governance systems. Many of these services were run by groups not affiliated to any of the bureaus, although some were co-ordinated by central bodies, for example the Uganda Protestant Medical Bureau (see later) or the HIV/AIDS Focal Point at the Catholic Secretariat. According to an official of the Focal Point, Catholic groups were quite individualistic in their approach, offering small scale interventions directed at HIV awareness.³⁵ This is a common situation across Africa (see Chapter 4, e.g. Sec 4.8.2). As a result, this study did not manage to obtain much information on the scale of these services.

Approximately half of the agencies assessed in the study were involved in home-based care services that varied considerably in scale (ranging from 20 to more than 7 000 patients on their books).³⁶ In the case of the Gulu region, it was reported that faith-based programmes offered a range of services, with VCT a common focus in rural areas; others provided adherence and other support to people on ART.³⁷ According to a 2001 survey in Uganda, 16% of agencies providing HIV-related and AIDS-related services were faith-based, with an emphasis on prevention, mitigation and capacity-building, and were described as having a “special edge on providing psychosocial support to people living with HIV and AIDS (PLWAs), the orphans, and the widows”.³⁸ These were largely grassroots groups that were fairly evenly distributed throughout the country, including its more remote areas where not many other services existed.

A total of 145 000 **traditional healers** (TH) were reportedly providing health services in Uganda, compared to 90 000 workers in the bio-medical sectors.³⁹ They were respected in their communities as indigenous resource persons with the potential to influence behaviour, but also as providers of health services that were “potentially effective and affordable alternatives” for treatment.⁴⁰

Traditional medicine was reported to be used extensively for day-to-day health care needs by the rural Ugandan population.⁴¹ In addition, traditional birth attendants were trained by the MoH and worked in collaboration with local facilities, referring patients where this was required.⁴²

Traditional and modern health practitioners together against AIDS and other diseases (THETA) was started in 1990 with the purpose of involving THs in the response to AIDS.⁴³ The association worked with traditional healers in HIV and AIDS education, counselling and improved patient care and had developed a curriculum for training THs in basic clinical diagnosis for AIDS. To date their programmes have impacted on more than 1 000 healers, of which 400 have undergone extensive 18-month training and 300 have been certified. It was estimated that as many as one million persons have benefited from their services.⁴⁴

33 Personal communication, Dr S Orach, UCMB.

34 Questionnaire data.

35 UCMB 2003.

36 Questionnaire data.

37 FGD Gulu.doc - 7:49 (129:129) & 7:50 (131:131).

38 AMREF-Uganda, 2001.

39 Dr Runumi in the MoH gave these figures. According to “Human resource for health” in AHSPR 2006/7 the combined health workforce in public and PNFP facilities was only 36,100.

40 AIDS Uganda 2007.

41 Kamatenesi-Mugisha *et al* 2006.

42 DHO Gulu.doc - 16:4 (16:16)

43 THETA 2007.

44 AIDS Uganda 2007.

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However, official recognition and more widespread collaboration with THs by public providers was still lacking. While the government acknowledged that “integration of traditional and complementary medicine ... has the potential to augment, strengthen and promote better health care for all”,⁴⁵ no policy framework had been adopted to enable such integration,⁴⁶ nor had issues like safety, efficacy or quality of treatment been addressed, or resources put aside to enable implementation. A draft policy on traditional and complementary medicine, intended as part of a comprehensive Public Private Partnership for Health (PPPH) policy, was yet to pass through the Ministry of Health to Cabinet and Parliament for approval.⁴⁷ On the other hand, no fully representative association of THs existed with whom government could negotiate the policy.⁴⁸

6.3.2 FAITH-BASED HEALTH NETWORKS

There were three medical bureaus in Uganda, namely (in order of seniority, regarding both duration and size): the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau and the Uganda Muslim Medical Bureau. As the newest of the three bureaus, the Uganda Muslim Medical Bureau was still in a phase of expanding its reach, while the older bureaus with their extensive services had taken the strategic decision to restrict physical expansion in favour of sustainability and quality during the current financially difficult period.⁴⁹

The bureaus’ primary mandate was to support and oversee health services within their separate denominations. The bureaus also worked closely together on most matters, especially regarding the relationship with government. One informant characterised their activities as follows:

The bulk of PNFP services is faith-based and the bulk of these is represented by the three medical bureaus. Whatever agenda we have followed, we haven’t taken it forward as religious, but as non-profit health sector. PNFPs are implementers. And the bureaus represent them at the national level, in front of the donors and they are a kind of broker and catalyst of agents of change for the network.⁵⁰

More detail on the wide range of functions of medical bureaus and some of their formalised joint structures were mentioned (see also Uganda country profile in Chapter 4) :

- General facilitation of health units;
- technical support on management of human resources, finances, the information system and governance through workshops;
- advocacy to strengthen the position of PNFPs and inform government and other role players of their specific situation and needs; develop the relationship with government; resource mobilisation from central government;⁵¹
- fund raising and distribution of funds received;⁵²
- mediation between donors and health units, e.g. drug donations;
- UPMB and UMMB jointly manage a small sub grant programme promoting PMTCT.⁵³
- UCMB has done extensive analysis on costing of services:

And the completeness of the minimum care package. Because everybody speaks of the minimum care package and nobody knows whether the units deliver it or not and to which extent. But we know. And we can monitor whether the extent to which the package is delivered increases or shrinks over time.⁵⁴

- UCMB has been instrumental in the modification of the health management information system for generation, analysis, and dissemination of information; this system is now adopted by the Ministry of Health. “It was commissioned

45 ROU 2006.

46 The National Health Policy of 2000 recognised the important role that TH could play in health care delivery. A policy draft regulating the interaction was prepared in September 2006 and was pending approval. See ROU 2006.

47 Personal communication, Dr. S. Orach, UCMB.

48 ROU 2006.

49 Personal communication, Dr S. Orach, UCMB.

50 UCMB.doc - 18:2 (9:9) &18:15 (31:32)

51 Mukono DHO 1.doc - 23:41 (68:68)

52 UMMB.doc - 21:2 (12:12)

53 UMMB.doc - 21:53 (163:163)

54 UCMB.doc - 18:33 (57:57)

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by us as an attempt of going towards a workload related staffing norm, rather than a bureaucratically established staffing norm.⁵⁵

- responding to new challenges: UPMB has developed programmes in its training schools to develop staff capacity in counselling to respond to increasing chronic illnesses;⁵⁶
- UMMB Mediates between its health units to ensure that equipment is shared, and staff rotated in order to build capacity and improve discipline;⁵⁷
- UPMB helps its health facilities to link to projects and programmes, specifically around HIV/AIDS and malaria, such as building capacity and management of ART;⁵⁸
- international networking , e.g. with Christian health associations in Kenya and Tanzania around best practices;⁵⁹

There is an informal relationship between the three bureaus, which has however resulted in some formalised structures. Joint activities include:

- the Joint Medical Stores; started in 1979; a legal entity with its own structures of governance, serving both PNFP units and those of governments and the private sector sourcing and distributing quality drugs and medical equipment;⁶⁰
- the bureaus worked towards forming a cartel of PNFP health training institutions; this did not come about formally, but they collaborate loosely on running their training schools;⁶¹

The Uganda Catholic Medical Bureau owns the biggest proportion of facilities, and UPMB has 258 health facilities distributed across the country; with the 'junior partner', UMMB, running 5 hospitals, as well as 6 health centre III's. and 62 health centre II's. In the latter case the number of facilities has increased by 30-40% in the last 5 years.⁶²

The **Inter-Religious Council of Uganda** was another network which brought together five different religious denominations in Uganda to address issues of common interest.⁶³ Among these issues was an AIDS programme with a focus on implementation through existing facilities and religious programmes at grassroots level, including the scaling up of ART provision at rural facilities. While the religious leaders of the groups involved had established this body, it had no effective system of governance.⁶⁴ More details on the functions of the Council are included in Appendix 6.1 (A), while Appendix 6.1 (B) lists the range of other networks which made a faith-based contribution to health in Uganda, either nationally or regionally: the impact of these networks is varied.

6.3.3 HEALTH FACILITIES

Overall, PNFPs provided 44 hospitals out of the total 104 hospitals in Uganda (that is, 42%), and 558 of the 2 536 lower level health units (that is, 22%).⁶⁵ PNFP facilities make up a varying fraction of the total number of facilities in different areas of the country and in different levels of facilities. Table 6.1 provides information on districts covered by the study.⁶⁶

These data illustrate the considerable scale of PNFP health facilities in Uganda as well as their emphasis on hospitals, rather than primary care. This imbalance reflects the historical evolution of PNFP facilities, most of which were built before the Primary Health Care movement. The district health officer (DHO) in Gulu took a critical view of this condition:

PNFPs have stagnated. ... The PNFP services are now dwindling, their impact is less. They could do more. Lacor [the main UCMB hospital in Gulu] has continued growing, may have over-grown. It should have gone out with its services. The need is for expanding health centres in other areas.⁶⁷

55 UCMB.doc - 18:34 (59:59)

56 UPMB.doc - 20:37 (85:85)

57 FGD Kampala 2.doc 10:1 (129:129)

58 UPMB.doc - 20:45 (110:112)

59 UPMB.doc - 20:46 (112:112)

60 UCMB.doc - 18:12 (25:27)

61 UCMB.doc - 18:14 (27:27)

62 UPMB.doc - 20:28 (71:71), UMMB.doc - 21:1 (6:10) & 21:29 (79:79)

63 IRCU.doc - 26:1 (5:5)

64 UCMB.doc - 18:6 (17:18)

65 UCMB 2007

66 Data for the 3 districts from MoH Clinical Services (quoting health facility inventory 2004), *Uganda Districts*, 2005, Other than for hospitals the source distinguishes between government and private facilities; the bulk of private are religious, but not all. No MoH hospital figures for Kampala were given.

67 Gulu DHO.doc - 16:17 (50:51).

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Table 6.1 Private and public health facilities in selected Uganda districts

	Kampala		Mukono		Gulu	
	MoH	PNFP	MoH	PNFP	MoH	PNFP
Hospitals	(1 tertiary)	7, incl 3 tertiary	1	3	2	1
Beds	2 800	1 100	100	350	350	460
	MoH	Private	MoH	Private	MoH	Private
HC IV	3	1	4	0	3	0
HC III	11 + 1 clinic	8	20	2 + 83 clinics	13	3 + 25 clinics
Dispensary	30	16 + 230 clinics	9	12	26	2

Note: HC I = Health Centre I: village health team with no facility

HC II = Health Centre II: outpatient department only

HC III = Health Centre III: outpatient department + ward, focus on maternal and child health;

HC IV = outpatient ward, theatre, laboratory + maternity – can handle complications.

While it would be desirable for future planning to shift the focus to providing more primary care, with the current financial constraints that seems unlikely, as this is the least sustainable level of care, both in terms of raising income through user fees and attracting staff.

Agencies assessed in the study varied greatly in the scale of their operations, some providing a single facility, while others operated more than ten (Church of Uganda) or even more than twenty (Catholic Medical Bureau). The scale of the facilities themselves also varied, ranging from 9 000 beds in the biggest agency to only a few in the smallest. Several agencies had more than 300 beds per facility. While the majority of facilities were owned by the agencies themselves, some were owned by the community, and occasionally the facilities were shared with other agencies.⁶⁸

Where it was possible to obtain data, facilities were constructed of brick. Electricity was most often reported to be 'sometimes available'; although in a few cases it was 'never available'. Access to water was most commonly described as being generally reliable; however, sources such as boreholes and communal taps were less so. About two thirds of facilities reported always having access to telephones, with the balance having either no access or intermittent access. Half of the sites had reliable e-mail access. In a quarter of the sites, ambulance or transport services were not available.⁶⁹ Regarding infrastructure at PNFP facilities, experiences ranged from being able to maintain government standards to lacking the basics (water and electricity, modern equipment, ambulances).⁷⁰ These responses were reflective of the varying conditions that existed on the ground, in particular between rural and urban facilities, but also between those of the well-established Catholic and Protestant bureaus and those belonging to the newer Muslim network, which was still getting off the ground and having to do so in difficult conditions.

Despite the problems faced by the PNFP facilities surveyed, they tended to be well resourced compared to the general conditions in the country. It must be emphasised, however, that the sample surveyed was mostly urban, where conditions were generally better, whereas the bulk of the PNFP facilities were located in rural regions. Nonetheless, key informants acknowledged that some of the PNFP facilities were model health providers. The Uganda Catholic Medical Bureau-affiliated Lacor hospital in Gulu, for instance, compared favourably with the regional referral facility in terms of equipment and staffing, and had a reputation that attracted patients from even beyond the borders.⁷¹

6.3.4 GEOGRAPHIC DISTRIBUTION

Agencies in the survey provided services in urban and rural areas, although peri-urban areas were a dominant group served by these agencies. In terms of the breakdown of locations from which clients were drawn, all agencies identified a primary location, while also noting that clients came from other locations too. Even where facilities were located in rural areas, these facilities were also patronised by those living in urban and peri-urban locations. The same applied to

⁶⁸ Questionnaire data.

⁶⁹ Questionnaire data.

⁷⁰ UPMB.doc - 20:30 (73:73), UMMB.doc - 21:14 (44:44) & 21:15 (46:46).

⁷¹ UNICEF.doc - 15:4 (12:12).

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facilities in urban areas, with a significant proportion of clients coming from rural areas.⁷² The implications with regard to time and transportation costs incurred by clients need to be explored further. It is likely that this pattern was a result of the shortage of facilities close to home, although the preference for faith-based services could also be a factor.

As indicated above, this survey was not conducted on a representative sample but had an urban bias. The consensus from PNFP representatives in most focus groups and other key informants (including the WHO representative) was that the bulk of PNFP facilities were rural, especially those with lower level units, while the major hospitals were located in the bigger centres. It must also be noted that in many cases hospitals were originally built in rural areas, but had over time attracted developments like a school or trading centres around them, so that their locations are no longer 'deep rural'.⁷³ The conscious focus for PNFPs, however, had been to serve those most in need – the poor and difficult-to-reach populations – in accordance with their mission; as a result a high proportion of rural facilities were run by PNFPs.⁷⁴

Box 6.2 Providing health services amid conflict

Gulu in the North of Uganda is only just emerging from 20 years of civil war. Over 90% of the population in the area were displaced with 1.5 million persons living in camps.

Some implications for health services:

- *high morbidity due to communicable diseases and psycho-social conditions in IDP camps*
- *complicated burn cases*
- *2 000 to 10 000 IDPs seeking safety from attacks crowding into hospital premises every night*
- *difficulties for IDPs returning to areas devastated by the war; and for the MoH trying to reach them with health services*
- *the added stresses on health staff and accordingly greater difficulties in retaining them*
- *competing for staff with 250 NGOs working in the area, many of them war-related*

Sources: Gulu FGD, KII in Gulu, St Mary's 2005/06

There were of course regional differences. In Kampala, for instance, there were a number of private for profit facilities, and even some of the PNFP facilities had high cost wards. In Mukono, the PNFP facilities are "equitably distributed throughout the districts. They are rural. They handle the poor".⁷⁵ Key informants from Gulu district health office (DHO), however, commented that church facilities were mainly either in big urban centres or semi-urban centres, and not enough was done for the more remote areas, especially those to which internally displaced persons were currently returning (see Box 6.2). The sentiment was that PNFPs should focus on areas where there were no government facilities.⁷⁶ It was not made clear, however, why that should be the responsibility of the PNFPs. Under current circumstances, it was understandable that they were not able to take this on, notwithstanding their commitment to serve the disadvantaged, as they barely had the resources to maintain existing facilities.

6.3.5 TRAINING SCHOOLS

The aspect of the health system in which the PNFP contribution was proportionally most significant was the training of health workers. Twenty of the 27 nursing and midwifery training schools in Uganda (that is, 71%) belonged to this sector, accounting for 60% of nurses and midwives in the country.⁷⁷ They provided excellent training, as acknowledged by the Director for planning in the MoH:

A nurse trained under the PNFPs performs much better than a nurse trained through the Ministry of Education. The quality is much better for PNFPs.⁷⁸

Further, the only training for health managers available in Uganda was offered by two Christian institutions.⁷⁹

PNFPs also placed a premium on offering career development opportunities to staff in their facilities and aimed to provide decentralised training facilities so that staff could train in the area from which they came. Both these strategies helped to

⁷² Questionnaire data.

⁷³ Mukono DHO 1.doc - 23:20 (31:31).

⁷⁴ UPMB.doc - 20:4 (11:11).

⁷⁵ Mukono DHO 1.doc - 23:42 (74:74).

⁷⁶ UNICEF.doc - 15:10 (22:22); Gulu DHO.doc - 16:14 (40:40).

⁷⁷ UCMB 2007.

⁷⁸ MoH.doc - 19:18 (45:45).

⁷⁹ UCMB.doc - 18:53 (60:60).

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retain staff.⁸⁰ The three bureaus had put in place scholarship programmes for all staff categories, with a focus on nurses, and had developed training programmes that equipped them for the conditions they experienced and for new needs in the health sector.⁸¹ One example was the growing need for counselling of patients with chronic illnesses. Sadly this strategy of developing a multi-skilled, competent work force did not always succeed as a means of retaining staff:

However, you find that those health workers who joined our network become competent. If you look at a health worker who has joined government, and one who has joined our network, over five years the one who has joined our network will be skilled, multi-skilled. We will have built their capacity – and those are the ones we are losing, because they become marketable ... [it] has made us vulnerable to the people who want skilled labour.⁸²

The training of high-quality health workers was a critical contribution of PNFPs to the Ugandan health system, yet one that seemed to get little support from the state. Instead the government poached the staff trained in PNFP training schools – a further frustrating element in the relationship between PNFPs and the MoH, especially since there is no shortage of medically trained people in the country. A member of the PPPH group claimed: “And you can find in Kampala, taxi drivers with a medical degree. You can find them here, no problem.”⁸³ These could be recruited directly from training schools, rather than from the PNFP facilities.

6.3.6 HEALTH-SUPPORTING AND PROMOTING ACTIVITIES

Besides their involvement in direct health services, whether facility-based or not, religious entities often offered services and activities that were supportive of public health, such as welfare and development services. This applied to about half of the agencies surveyed by this study. They provided very tangible services to orphans and vulnerable children (OVC), economic empowerment and poverty alleviation in addition to food parcels, and care for refugees. Additionally, they provided psychosocial support, spiritual guidance and pastoral care for the sick. Some agencies undertook monitoring and evaluation and advocacy work, and some provided information regarding skills development or leadership. Most agencies described work related to achieving behaviour change (with respect to risky behaviour and in relation to sex education), generally targeting youth but also mothers, and sometimes including health messages on topics like immunisation. The proportion of time committed to health versus non-health activities varied widely, presumably in accordance with the goals of the agency, although availability of funding could not be discounted as a contributing factor.⁸⁴

Further examples were given by agencies of providing seeds and implements to achieve food security, general counselling services, spiritual guidance and sensitisation about diseases such as Ebola or HIV.⁸⁵ A study of faith-based OVC programmes in Uganda reported a range of services provided, ranging in scale from congregation level projects offering material and psycho-social support to up to 50 OVC, to NGOs with an average of 1 000 OVC in their care. The less formal initiatives were usually reactive rather than pro-active, acting as seasonal ‘shock absorbers’.⁸⁶

Their community base offered opportunities for PNFPs to work in ways and in areas that were not available to state entities. Primary among these was the potential for health promotion in communities. A number of key informants confirmed the role religious leaders played in health promotion, for instance by supporting within their networks messages on vaccination or promoting antenatal care and prevention of HIV.⁸⁷ Those religious leaders who had received training regarding the content of health promotion were effective at transmitting the messages, due to the respect with which they were regarded in communities. In addition they were regarded as more suited for some aspects of HIV-related services, like family support, psycho-social care, and palliative care because “a religious leader does it better than a medical worker. Because he uses the spiritual part of appealing to talk to these people”.⁸⁸

Compared to the prominence that this role for religious leaders had in Mali (see Chapter 7), it was surprising that not more was made of it in Uganda, with its much-documented campaigns against HIV. One reason for this may be that

80 PL.doc - 17:30 (60:60).

81 UPMB.doc - 20:36 (85:85).

82 UPMB.doc - 20:36 (85:85).

83 PPPH.doc - 22:20 (43:43).

84 Questionnaire data.

85 FGD Gulu.doc - 7:51(132:133) & 7:15 (53:53).

86 Muhangi 2003.

87 WHO.doc - 14:12 (106:106), IRCU.doc - 26:16 (92:92) & 26:17 (92:92).

88 Mukono DHO 1.doc - 23:30 (45:45) & 23:29 (45:45).

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religious leaders do this work as part of their routine rather than as part of projects, so that the work is not accompanied by the distribution of commodities, nor publicised on radios and through posters. Religious leaders were consequently 'invisible' and their impact was easily attributed to more visible players.

In summary it can be stated that the capacity of religious entities in Uganda to deliver health services and promote health and well-being, though hampered by resource constraints, was nevertheless strong. This sector was an asset to the country and the health system and deserved to be strengthened.

6.4 PNFP COLLABORATION

6.4.1 COLLABORATION WITH GOVERNMENT

PNFPs were appreciative of the recognition they received from government in various forms. For example, PNFP representatives participated in the National Health Assembly, the Joint Review missions with donors and government, and the health policy advisory committee.⁸⁹ In addition, a central organ for collaboration with government was PPPH, formed in 2003,⁹⁰ with a PPPH Working Group for the Health Policy Advisory Committee including representatives of the donor community, MoH, PNFP, private-for-profit and traditional and complementary medicine as members. A draft policy had been developed, stipulating a partnership between PNFPs and government, rather than competition, which also spelled out how resources, especially financial resources, were to be allocated. Unfortunately the policy had not been fully implemented and recommended posts for district focal persons for PNFP collaboration had largely not been filled.⁹¹ This delay was due, among other factors, to a change of leadership in the Ministry, along with a change of attitude towards PNFPs, and misguided attempts to include providers of natural and herbal therapies in the same policy.⁹²

For the national government, collaboration was not only about increasing efficiency but also about acknowledging that part of the responsibility for the health of Ugandans was borne by private providers.⁹³ Government had a lot to gain from this partnership and was clear on what it expected in return for its subsidy: a reduction of user fees at PNFP facilities, which in turn would improve coverage.

Initially there was mutual suspicion between the partners, with PNFPs fearing that they might lose their autonomy and government uneasy about supporting something without being fully in control of it.⁹⁴ Some of these doubts and frustrations lingered on. For the PNFPs, these centred on several issues:

- a sense of not being taken seriously as partners, expressed by one informant as follows: "they like our data, but we are not a planning priority at district level, notification comes late"⁹⁵; and by another: "We are remembered last ... They are putting us at the bottom always. It is not proper"⁹⁶
- poor communication from the MoH (for example, around changes to the ART regimen,⁹⁷ and
- failure to implement decisions that were made in the course of negotiation.⁹⁸

In addition, the issues raised by the MoH for discussion tended not to be about the main concern for PNFPs, namely, human resources. Instead, they focused on logistical or technical problems like reforming the accounting or health information system, or how to increase the vaccination coverage, issues on which PNFPs might not feel they had a particular contribution to make.⁹⁹

The only current concern raised by representatives of the MoH was about some facilities being given PNFP status, and hence benefiting from the budget allocation, where the criteria for admission seemed doubtful.¹⁰⁰ Yet, on the whole there was a positive sense about the collaboration, as expressed by a member of the PPPH: "The main thing, individuals have problems, but the PNFP sector never made opposition against anything of the government rules and regulations

89 UPMB.doc - 20:26 (66:66).

90 MoH.doc - 19:8 (32:33).

91 FGD Mukono.doc - 8:84 (230:230), UPMB.doc - 20:20 (49:49).

92 UPMB.doc - 20:25 (62:62), PPPH.doc - 22:39 (71:71).

93 MoH.doc - 19:1 (14:14).

94 MoH.doc - 19:8 (32:33), 19:10 (35:36) & 19:11 (37:37).

95 FGD FGD Kampala 1.doc - 9:5 (101:101).

96 UMMB.doc - 21:63 (203:203).

97 FGD - Kampala 1.doc.

98 WHO.doc - 14 (122:126); UPMB.doc - 20:24 (56:56).

99 UCMB.doc - 18:27 (51:51).

100 Mukono DHO 1.doc - 23:53 (88:88) & 23:54 (96:97).

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and policies.”¹⁰¹

Despite strong commitment to collaboration within the MoH, it proved difficult to implement at district levels:¹⁰² “Because the districts had the autonomy to choose who and to what extent they collaborate with, this policy of collaborating with faith-based organisations did not move that fast”.¹⁰³ There is reluctance to fully collaborate with PNFPs, partly because of competition for staff and other resources:

*When we talk with the local authorities there, it seems they consider the PNFP like a sort of competitor for the health resources. So integration at a local level is more difficult than at a national level. Because there, it is touching the budget.*¹⁰⁴

Yet it was at district level where the real nitty-gritty of collaboration needed to happen. The district level was where funds were shared with PNFP facilities and staff members were recruited. It was where the challenge was for the bureaus to create the linkage that would make a difference to their facilities.¹⁰⁵ There were, however, examples of good practice in certain districts, including some functioning collaboration structures. In Wakiso district the chair of the PNFP collaboration was accessible and an open relationship existed.¹⁰⁶ The situation in Mukono seemed exemplary and is described in some detail in Box 6.3. Appendix 6.2 provides more detail of other examples of functional collaboration, including structures, systems and practical achievements. This shows that, despite the problems at district level, functional partnerships did exist, especially around crises and when there were special needs.

6.4.2 COLLABORATION BETWEEN PNFPs

Box 6.3 Example of good collaboration practice: The district of Mukono

In this district 20 km outside Kampala, all those working for health seem to follow the philosophy “not to make them enemies but to make them friends so that we work together”

1. Collaboration between government and PNFPs

In the district health team, PNFP representatives meet regularly with members of the District Health Office and they are fully involved – and heard – in planning processes. There is open communication and joint decision taking on issues like determining user fees.

It is one of the few districts where a PNFP focal person has been appointed to direct and follow up on PNFP-related issues. The district health office is fully behind its PNFP contingent, supporting their health units by seconding staff and encouraging them to network among themselves.

The role of religious leaders for health promotion is certainly valued here, respecting that, once they have been given information on health matters, religious leaders need to find their own ways to respond. So the district health office makes available a meeting place for them to deliberate. On Catholics and condoms the District Health Officer said: “What is important is understanding their belief and their values and then you go with them.”

2. Collaboration between PNFPs

There was an active private not-for-profit coordination committee with the District Health Officer as an ex-officio member. Members conducted quarterly meetings and seminars and arranged exchange visits between PNFP units. They used these opportunities to learn from each other, sharing skills on reporting, budgeting, strategic planning and health management information systems. The coordinator of the committee acted as liaison person with the District Health Office.

3. Collaboration of PNFPs with traditional birth attendants

Here too the approach is to find the best possible way of working together. Nurses and midwives are encouraged to supervise and train traditional birth attendants, particularly in modern, safe means of delivering and help them to recognise danger signs during pregnancy in order to refer patients to health centres.

Sources: Mukono FGD, Interviews with officers of the District Health Office

101 PPPH.doc - 22:26 (47:47).

102 WHO.doc - 14:14 (122:122).

103 PL.doc - 17:9 (22:22).

104 PPPH.doc - 22:10 (25:25).

105 UPMB.doc - 20:34 (82:83) & 20:47 (114:114).

106 FGD Kampala 1.doc.

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Big international NGOs like World Vision tended to collaborate amongst each other rather than working with small indigenous FBOs. However, some did use local FBOs for implementation of activities such as counselling and testing, helping to equip them for these functions through workshops.¹⁰⁷

Among facilities affiliated to each of the three bureaus, however, there was a high degree of collaboration. This was also in evidence between the bureaus and other PNFP networks. (see Section 6.3.2).

Focus groups were asked to comment on the need for intermediary organisations to improve collaboration, also as a way of overcoming the resource constraints discussed elsewhere in this report. Responses indicated that the medical bureaus were seen as serving this purpose, and highlighted some concerns that other intermediaries might simply serve their own interests. There were also perceptions that at times services were outsourced to overcome weaknesses.¹⁰⁸ It did seem that, for the higher-level facilities, the bureaus were able to perform an intermediary role, offering co-ordination and supervision, capacity building, and a common voice in communication with government. The fact that so little was known about the non-facility-based activities of religious entities did, however, indicate that there was a need for intermediary organisations working at this level, supporting this more loosely structured and more vulnerable dimension of the health-supporting functions of religious groups. Support was particularly required on reporting, fund-raising, management and governance

6.4.3 COLLABORATION WITH TRADITIONAL HEALERS

Informants hardly commented on the reality or value of traditional healers and traditional birth attendants, except in the model collaboration district of Mukono (see Box 6.3). Here traditional healers were organised and had an office in the district health complex. An AIDS educator specifically targeted traditional healers in the district. Traditional birth attendants were also trained and engaged, receiving kits for safer delivery; in return they referred mothers with their children to health centres for immunisations.¹⁰⁹ More examples of collaboration occurred, e.g.

- dialogue around ante-natal care, hygiene and malaria;
- sensitisation so THs and TBAs refer patients to health centres if needed;
- there are instances where traditional birth attendants do their round in the wards after the official round; generally, however, they operate more in secret;
- THs plant their medical herbs in the hospital grounds.

The only area where collaboration was difficult was in urging traditional healers to refer patients to health centres as 'they know that they are going to lose their market.'¹¹⁰

Several PNFP representatives expressed negative sentiments about the potential of collaboration with traditional healers, tending towards caricature, while others accepted the reality that patients visit healers and even expressed that "We can learn from them, too." In this positive vein, the Catholic health network in Mukono had developed a number of community resource persons, including traditional healers, to strengthen their community involvement.¹¹¹

6.5 SOURCES OF FINANCIAL AND MATERIAL SUPPORT

6.5.1 GOVERNMENT FUNDING

Historically, missionary hospitals were funded by the European and North American hospitals that founded them. These original donors had been easy to approach, only requiring an official "to write one sentence to say we want money to put up a house for nurses, and the money would come".¹¹² Support from this source had decreased significantly.¹¹³ The current trend was a shift towards the sector-wide approach with most funds going into government's central 'basket'.¹¹⁴ This change had made PNFPs turn to government for financial support.

107 PL.doc - 17:25 (50:50), FGD Gulu.doc - 7:54 (139:139)

108 FGD Kampala - 1.doc.

109 FGD Mukono.doc - 8:47 (130:130)

110 Mukono DHO 2.doc - 24:16 (74:76), 24:17 (78:78) & 24:19 (96:98)

111 FGD Mukono.doc - 8:52 (138:138).

112 FGD Mukono.doc - 8:67 (186:186).

113 PL.doc - 17:32 (62:62).

114 UPMB.doc - 20:31 (73:73).

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In Uganda, government support for PNFPs started in 1998/99. The subsidy increased rapidly from 4.4 billion shillings¹¹⁵ (US\$2.6m), to 17.74 billion shillings (US\$10m) by 2002/03 where it has remained ever since, despite the increasing costs of providing health care.¹¹⁶ The government subsidy was used for procuring drugs and other supplies and to pay some staff allowances. Higher-level facilities like hospitals might get funding directly from the Ministry of Finance while lower level health facilities received primary health care funding through the district, together with certain supplies.¹¹⁷ This funding covered maintenance of the units, drugs, and staff allowances, as well as outreach services.¹¹⁸ Reporting was required along specified budget items.¹¹⁹

Box 6.4 Undertaking number One

At the end of the joint review of the health sector the different stakeholders agreed on this limited number of undertakings for the next 12 months. But now for 3 years consecutively the undertaking number one said that the health sector budget should cater for funds to close the remuneration gap between PNFP and public health workers, in order to stop the drainage of human resources from the PNFP to government health centres. And that government health centres recruit really new people that came on the job market, because a lot of nurses and doctors and all the health staff are trained and are coming on the job market.

To date this undertaking has not been implemented.

Source: PPPH.doc - 22:20 (43:43).

Apart from the fact that the funding was clearly insufficient (“chicken feed, truly speaking, if you compare it to the work”, as one respondent noted¹²⁰), it was unpredictable both in terms of timing and amount, as in times of crisis government cut back its allocations to PNFPs. Delivery of essential drugs could also be delayed.¹²¹ As a result facilities were substantially under-resourced, with the Uganda Muslim Medical Bureau estimating that it only had about 35% or 40% of the funds it required for operation of its facilities.¹²²

Government did face a dilemma regarding its support of private facilities, even though they were not-for-profit, in that the public sector was itself experiencing acute shortages and had the added pressure of providing free services for the benefit of patients. This challenge accounted for the fact that none of the additional 32 billion or 30 billion shillings (US\$19m) that was available for the health sector in the 2007/8 fiscal year was put towards an increased subsidy to the PNFPs.¹²³

Nonetheless, PNFPs expected that their contribution of more than 30% to health provision in Uganda should be funded at a level that acknowledged the extent of their contribution, especially as these services came ‘cheap’ to government, given PNFPs own contributions.¹²⁴ After all, if the PNFPs had not existed, the government would have had to provide almost double their current workload – and they would be “messaging up”.¹²⁵ Some MoH actors admitted that what they granted was not commensurate with the service burden faced by PNFPs.¹²⁶

6.5.2 SECONDMENT OF GOVERNMENT STAFF

Another form of government support was the secondment of MoH staff to PNFP facilities and the paying of their salaries by government. These staff members had originally all been doctors, but recently nurses had also been seconded to lower level units.¹²⁷ These doctors and nurses made up approximately 4% of the PNFP workforce.¹²⁸

Seconded staff members were paid at public service rates, which tend to be higher. This salary discrepancy within a single unit often caused tensions between equally qualified staff, although it seemed that PNFP staff members appreciated the lightening of their workloads and the opportunity to take leave that this allowed.

115 Uganda Shilling (USH or UGX) 1700 USH = 1 US\$ (Jan 2008)..

116 PPPH.doc - 22:19 (42:42).

117 UNICEF.doc - 15:7 (16:16).

118 FGD Gulu.doc - 7:22 (69:69); FGD Gulu.doc - 7:24 (73:73).

119 UMMB.doc - 21:71 (234:234) & 21:67 (222:223).

120 FGD Mukono.doc - 8:64 (180:180).

121 FGD Kampala 2.doc - .10:3 (193:193)

122 UMMB.doc - 21:64 (207:207).

123 PPPH.doc - 22:22 (44:44)

124 UMMB.doc - 21:54 (169:169)

125 PPPH.doc - 22:29 (51:51)

126 MoH.doc - 19:33 (83:83)

127 FGD Mukono.doc - 8:79 (213:213); Mukono DHO 2.doc - 24:6 (22:22).

128 UCMB 2007.

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Clearly government recognised the value of the PNFP sector and was aware of its responsibility to provide support in the current human resource crisis. Yet this aspect of the relationship between government and PNFPs was the most fraught, with high levels of frustration on the side of the PNFPs, which considered the government partly responsible for the crisis. First, recent developments in human resource policy (such as salary top-ups) had created better working conditions for health staff in public facilities, which PNFP facilities were not able to mimic.¹²⁹ As a result, many former PFNP staff members had been recruited to public facilities, leaving an even greater gap behind. Second, the decentralisation policy had placed responsibility for health services at the district level. This too had encouraged the flow of staff from PNFP to public facilities. While the MoH at national level was eager to support PNFP facilities, this did not necessarily happen at district level, where decisions about actual collaboration and staff secondments were taken.¹³⁰

PNFPs were frustrated that the government had not implemented its undertakings (see Box 6.4). While PNFPs only required about 8,5 billion shilling (US\$ 5m), which was half of the current annual subsidy,¹³¹ to achieve parity of salaries at current salary levels, public salaries were due to increase again soon, skewing the disparity even further.

6.5.3 USER FEES

User fees were a large funding source for most PNFPs. In urban facilities that served populations capable of paying for services, fees can make up over 90% of total funds.¹³² Further away from towns, there was greater reliance on government and donor funding.¹³³ In 2006, the typical breakdown of funds in Uganda Catholic Medical Bureau facilities was 22% from government, 38% from user fees and 40% from donors (the latter having increased from 22% in the previous eight years).¹³⁴

The need to charge user fees had always been problematic, as they acted as a barrier to access (often with catastrophic consequences),¹³⁵ but PNFPs had not been able to afford to abolish fees, along with the public sector, because of financial pressures. Once government started subsidising PNFPs, this additional income was used to lower fees “transforming these subsidies into access for the poor”.¹³⁶ Thus, from 1997/98 to 2005/06, access to a 65% sample of PNFP hospitals increased by 66% in terms of standard units of output (although there was a slight decrease in the 2005/06 figures compared to the previous year, following the stagnation of the subsidy).¹³⁷ Primary targets for user fee reductions tended to be children under 5 years and pregnant women, in accordance with the commitment of PNFPs to reach the vulnerable and under-privileged. In some cases – as in Lacor, Gulu – donor support had made it possible to completely abolish fees for these patient groups.¹³⁸

6.5.4 DIRECT DONOR FUNDING

The main source of funding for health in Uganda was from global initiatives and multi-lateral organisations like the European Union.¹³⁹ The bulk of this funding went to government but some funders – particularly the US government – dealt directly with faith-based organisations.¹⁴⁰ Accessing these funds could be difficult, however, given competition between many organisations.¹⁴¹ More details on specific funding partners appear in Appendix 6.3.

6.6 STAKEHOLDER PERCEPTIONS OF PNFP SERVICES

In 2003 a World Bank report based on a quantitative survey¹⁴² compared government, private for-profit, and private not-for-profit (religious) providers of primary health care in Uganda. The study found that religious not-for-profit facilities were

129 PPPH.doc - 22:18 (41:41).

130 PL.doc -17:9 (22:22)

131 PPH.doc - 22:30 (54:54) & 22:29 (51:51).

132 Some examples of user fees as percentage of budget for PNFP facilities in Kampala were given; (The figures are percentages of running costs; they do not cover capital development):

- St Stephen: 20% of budget; 15% came from government; balance from donors.
- Kibuli Muslim Hospital: user fees made up 70%, government subsidy about 8%. High cost wards subsidised the lower cost ones.
- Rubaga Hospital, St Raphael and Mengo: they made up 94-96% of running cost.

133 PL.doc - 17:31 (62:62).

134 UCMB.doc- 18:45 (83:83).

135 PPPH.doc - 22:14 (35:35).

136 UCMB.doc- 18:36 (67:67).

137 UCMB 2007. SUOs reflect the following data: IP, OPD attendance, ANC, Immunisation and deliveries.

138 PL.doc - 17:20 (41:41) & 17:21 (42:42).

139 PL.doc - 17:34 (62:62) & 17:36 (64:64).

140 PL.doc - 17:35 (64:64).

141 UMMB.doc - 21:6 (20:20).

142 Reinikka & Svensson 2003.

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more likely to: provide pro-poor services and services with a public good element; charge lower prices for services than for-profit units; and provide better quality care than their government counterparts,¹⁴³ although government facilities had better equipment.

This study supports these findings. There was a general sense, from the full range of stakeholders including government officials, that PNFP facilities were able to do more with the same resources compared to public facilities.¹⁴⁴ PNFPs were perceived as accessible, achieving good utilisation rates for poor communities.¹⁴⁵ In some cases they offered more services than government facilities (such as circumcision offered by Muslim clinics, home visits, and counselling by trained counsellors).

In addition, they were seen to have better infrastructure, be better staffed and have more reliable support services, especially drug supplies. This contributed to the widely held perception of *better quality* services. In Gulu a FGD member reported that a survey among clients showed a high satisfaction rate.¹⁴⁶ Mengo hospital, a PNFP facility in Kampala, conducted a survey in 2002 on the perceptions of nursing care at the facility. The results showed that staff members were more available there than at public facilities nearby, and hence patients were confident that they would be attended to.¹⁴⁷ This was despite the ongoing difficulty of attracting and retaining skilled staff.¹⁴⁸

Finally, PNFP services appeared to be more efficient.¹⁴⁹ As an official from the MoH stated:

*The unit costs for health services in the PNFPs are much lower than from government. So we know a shilling invested in through the PNFPs has higher rate of return than one in the government.*¹⁵⁰

A WHO informant confirmed this, claiming that in many cases clients expressed their 'vote' for PNFP services by making use of them despite their cost¹⁵¹ and even when there was a public facility "less than 100m away".¹⁵²

The positive performance of PNFP services received acknowledgement from the MoH through the secondment of MoH staff to PNFP facilities, the provision of grants for immunisation and school health programmes on behalf of the government, and support for the PPPH.¹⁵³

Reasons advanced for the accessibility, efficiency and quality advantages of PNFP-provided services include:

1) The values base that guides service provision

The faith base of the PNFPs was regarded as a distinguishing characteristic (in contrast to the technical content of their service which was defined by government guidelines in the same way as those of any other facility). These values translated, firstly, into explicit commitments to serve low-income communities.¹⁵⁴ Thus, some of the agencies assessed by the study included special mention of meeting the needs of the most vulnerable in their mandates. Terminology relating to promoting life, quality services, sustainability and cost-effective service provision was also evident.

Second, the fact that PNFPs felt accountability to 'the people of God'¹⁵⁵ led to improved monitoring and feedback. For example, the UCMB expected all its health units and levels of co-ordination to monitor their output in terms of indicators for access, quality, efficiency, staff productivity and equity.¹⁵⁶ The Bureau gave feedback to the hospitals and dioceses under the same framework and was even influencing the MoH to use this concept for its national assessment.

143 The quality measure is based on observed treatment practice, observed supply (that is, availability of health infrastructure), prescription practices, and exit poll data.

144 WHO.doc - 14:3 (40:40), UNICEF.doc - 15:14 (27:27), MoH.doc - 19:9 (34:34), Gulu DHO.doc - 16:16 (46:47), Mukono DHO 2.doc - 24:8 (35:35).

145 UPMB.doc - 20:11 (28:28).

146 FGD Gulu.doc - 7:39 (101:101).

147 We tried to obtain a copy of this study, but have not succeeded.

148 Mukono DHO 1.doc - 23:4 (11:11).

149 IRCU.doc - 26:42 (194:196).

150 MoH.doc - 19:17 (44:44).

151 WHO.doc - 14:8 (84:84).

152 FGD Mukono.doc - 8:6 (51:51).

153 FGD Kampala 2.doc - 10:4 (71:71).

154 FGD Mukono.doc - 8:24 (72:72), PPPH.doc - 22:2 (21:21).

155 UCMB.doc - 18:20 (37:37).

156 Dr S. Orach of the UCMB.

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Third, health workers were motivated to treat patients with dignity and respect.¹⁵⁷ As one informant put it, “There is a strong motivation. We can always make appeal to something that others find difficult to appeal to.”¹⁵⁸ Thus, FGD members in Kampala referred to the “special touch” among staff members, who had time and understanding for patients.¹⁵⁹ Staff were also resourceful in bringing their services to their clients: “People will put a vaccine carrier on their bicycle or even walk with it on foot, sit under a tree, give services”.¹⁶⁰

Fourth, PNFPs’ faith base might also account for institutions taking decisions that were risky (such as lowering user fees despite financial difficulties), trusting that this measure would enable them to fulfil their commission to the poor and yet not work to their detriment.¹⁶¹ At the same time this very motivation might act to the disadvantage of PNFPs as it prevented the medical bureaus from taking the one action that might get their plea to government heard:

*The temptation would be, when you have exhausted all the channels of communication, when all the evidence that you proposed doesn’t work. When reason doesn’t work, you only have threats. That we cannot use ... Ethically, it is a road that is closed to us. And therefore we are weak.*¹⁶²

2) PNFPs are grounded in communities

Religious groups were ‘grounded’ in all communities, their presence easing access for services.¹⁶³ PNFPs were often located ‘deep in the villages’ where there were no other health services.¹⁶⁴ They were also useful channels to mobilise communities.¹⁶⁵ Traditional healers, in particular, gave culturally sensitive service, and showed flexibility regarding payment.¹⁶⁶

3) The provision of spiritual and follow-up support

The fact that spiritual care was offered alongside physical care was regarded as helpful for the clients, especially at the end of life.¹⁶⁷ In addition, the connection between the facility and a religious congregation offered the possibility of follow-up care and, in general, holistic care that went beyond medical needs.

4) Strong structures and systems of governance “We are setting the standards.”¹⁶⁸

This was another feature of PNFPs. Working conditions were indeed quite different in the PNFP sector than it was in government facilities, as shown by the comment of an influential decision maker in an international NGO supporting the health system in Uganda:

*The management there is quite good, disciplining the staff there and looking at how they really do their work, and a little bit of motivation.*¹⁶⁹

Specifically the PPPH group mentioned that in PNFP hospitals the director was often trained in both medicine and management. The fact that the authority was close at hand at PNFPs accounted for better discipline, better supervision and stricter financial management.¹⁷⁰ The availability of essential drugs and diagnostic equipment – which was often not the case at public facilities – was another factor motivating staff to remain at these facilities despite lower pay.¹⁷¹ As quoted in the World Bank study, “Thus, working for God appears to matter!”¹⁷²

5) Weaknesses

There were, however, some weaknesses inherent in the PNFP sector. One was their raising of user fees. It was acknowledged that clients had a perception that services should be free – in keeping with the missionary spirit of old

157 PPPH.doc - 22:46 (94:94).

158 UCMB.doc- 18:35 (66:66).

159 Kampala 1.doc - 9:7 (20:20), FGD Mukono.doc - 8:2 (48:48).

160 UMMB.doc - 21:34 (95:95).

161 UCMB.doc- 18:37 (68:68).

162 UCMB.doc- 18:38 (70:70).

163 IRCU.doc - 26:35 (168:170).

164 FGD Mukono.doc - 8:18 (62:62).

165 FGD Mukono.doc - 8:48 (131:131).

166 FGD Kampala 1.doc - 9:2 (192:192).

167 FGD Gulu.doc - 7:13 (51:51).

168 FGD Kampala 1.doc - 9:3 (111:111).

169 UNICEF.doc - 15:17 (29:29).

170 PPPH.doc - 22:43 (86:86) & 22:44 (87:87), Mukono DHO 2.doc - 24:9 (37:37).

171 FGD Mukono.doc - 8:3 (49:49), FGD Gulu.doc - 7:68 (176:176).

172 Reinikka & Svensson, 2003.

Box 6.5 Levelling user fees: “You have to sell a chicken ...”

When you come to out-patients, you are sick. What the patient knows is that “I have a fever and I am unwell” and he cannot guess whether this disease will require ten thousand shillings or thirty-thousand shillings. ... Of-course, the facility will be making a lot of losses on some patients and we will also be getting marginal profits on some others. But in the end it is more predictable if people know, you have to sell a chicken and you will get the care you need at the hospital.

Source: PL.doc - 17:16 (31:31).

(and with conditions at public facilities). Yet even then the user fee was still lower, in effect, than what was paid at public facilities, where patients might be expected to ‘pay under the table’ to ‘facilitate the nurse’ before getting any service, as officials of the MoH and PPPH members admitted.¹⁷³ In addition, drugs would be available and included in the fee; at public facilities patients would get a prescription and have to buy medicines.¹⁷⁴

Despite these realities, the fact remained that the user fees, low as they were, did deter some patients from using the facilities.¹⁷⁵

There was no uniform policy regarding clients who arrived at facilities and were unable to pay; in some cases they would be treated anyway;¹⁷⁶ in others they might receive some first aid and be advised to go to a public health centre.¹⁷⁷

6) Religious motivations

A concern was raised that faith-based services might be sectarian or used as a channel to win adherents, although the informant did acknowledge that this was no longer so.¹⁷⁸ PNFPs confirmed that indeed their facilities were open to all in as much as health cut across religion, even though clients might have a preference to attend facilities of their own denomination.¹⁷⁹ A shift in perception about PNFPs had come about, according to a District Health Officer, since:

- the PNFPs were drawn into the system through the subsidy
- community leaders had become involved in budgeting for these facilities, hence regarding them as ‘their facility’
- PNFP facilities had been able to participate in government programmes as a result of the subsidy, and
- PNFP facilities were in some cases placed in charge of the health sub-districts.¹⁸⁰

Nonetheless, members of the focus group did recognise that religious language was potentially exclusive and ‘unhealthy’ (for example, the refusal to promote condoms, the denial of post-abortion care, and the theology of some churches that stated “you are saved and need no medicine”).¹⁸¹

When asked if their religious beliefs impacted on the services they provided, about half of the agencies explained that their religious convictions limited their health messages in some way.

For example, Catholic and Islamic organisations did not promote abortions or “artificial methods of contraception”, including condoms, due to their religious convictions (although there might be counselling around family planning).¹⁸² None of the key informants from the MoH or agencies like WHO who commented on this regarded the issue as problematic since these services could be accessed elsewhere.¹⁸³ Both DHO officers in Mukono stressed that religious convictions about such matters had to be respected, and that there were open lines of communication around this issue between their office and ‘the bishops’.¹⁸⁴

This fitted well with the stance Uganda developed in its HIV prevention campaigns, allowing different actors to make their specific contribution according to their values and capabilities rather than expecting all to have the same role. The only critical comment was heard in one focus group (Kampala lower units), on the failure to make condoms available

173 Mukono DHO 2.doc - 24:10 (41:44); PPPH.doc - 22:33 (59:59).

174 FGD Kampala 2.doc - 10:5 (41:41).

175 FGD Kampala 1.doc.

176 FGD Mukono.doc - 8:26 (73:73).

177 UMMB.doc - 21:46 (133:133).

178 MoH.doc (21:22).

179 FGD Kampala1.doc.

180 Mukono DHO 1.doc - 23:32 (53:53) & 23:33 (54:55).

181 FGD Kampala 1.doc - 9:8 (138:142).

182 Questionnaire data.

183 WHO.doc - 14:6 (57:57); UNICEF.doc - 15:8 (18:18).

184 Mukono DHO 2.doc - 24:11 (48:48).

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even to discordant couples; and on the lack of services targeting youth on issues such as abortion, unwanted pregnancy and early marriage.

6.7 CONSTRAINTS

6.7.1 A SHORTAGE OF HUMAN RESOURCES: "AN EXODUS OF HEALTH WORKERS"

When asked what restrained the capacity of PNFP health services, respondents most commonly referred to the crisis in human resources: "an exodus, not a shift of health workers".¹⁸⁵ A recent census assessed the human resource gap in the health sector and found that the gap in the PNFP facilities represented 54% of the overall gap (that is, a shortage of 1 974 medical/clinical staff and 657 others).¹⁸⁶ Considering that PNFPs provided about 30% of health services, it was clear that they were under more severe strain than other players.

Apart from the general shortage of funding, one of the causes of this problem was the increased salary packages negotiated by the government with the World Bank; once recruitment began it was PNFP staff who responded, attracted not only by higher salary packages (PNFPs paid 65% to 85% of public salaries), but also by more reliable pension schemes and shorter working hours.¹⁸⁷

In short, a lighter workload, the possibility to press for higher salaries, the ability to work privately during official working hours to top up one's income - all of these factors added to the attraction. Indeed, two thirds of the respondents to the survey thought that the conditions experienced by staff working in FBO facilities were different to those in the public health system.¹⁸⁸

Staff turnover in surveyed agencies was generally reported as high, although it was low in some facilities. The main groups leaving were nurses and midwives although other groups included medical officers as well as laboratory technicians. The impact of the high turnover was that junior staff members were often appointed in the place of the departing experienced staff, resulting in patient disappointment, loss of trust as well as heavy workloads for remaining staff until such time as vacated posts could be filled.¹⁸⁹

As a result PNFP facilities were not staffed according to government specifications.¹⁹⁰ They lost staff to bigger hospitals, public and private for-profit facilities, NGOs or specially funded programmes for vertical interventions within public or private facilities, all of which were able to offer better remuneration packages. However, the biggest drain on staff was the public sector. During 2005/6, PNFPs lost 16% of their staff component; attrition among the specific cadres of enrolled nurses and midwives, the cadres that provided the bulk of care to patients, was 46% in the same year. At least 40% of these, but possibly almost twice that number, joined government.¹⁹¹ This situation seems all the more frustrating, considering that often the departing staff members were trained in PNFP training schools.

One approach used by PNFPs to compensate was the use of volunteers. Of the 16 organisations responding in the questionnaire, only two did not use volunteers. In addition to a contribution to transport costs, volunteers almost always were reported to receive a stipend. This varied considerably from 10 000 to 200 000 U shillings a month.¹⁹² Volunteers were sourced from the global denominational networks, including medical staff;¹⁹³ but the numbers were decreasing, and at times they were only willing to come for very short-term placements.¹⁹⁴

6.7.2 CONSTRAINTS AROUND FUNDING

An important factor limiting the capacity of PNFPs to provide health services was their **lack of funding**, as discussed earlier. The major implication of the lack of funding was the impact this had on the ability to hire and retain staff.

Another funding-related problem was **funding restrictions and exclusions**. PNFP representatives expressed a number

185 UPMB.doc - 20:21 (50:50).

186 UCMB 2007, MoH 2003.

187 UPMB.doc - 20:22 (52:52); UMMB.doc - 21:19 (57:57); FGD Mukono.doc - 8:82 (222:222).

188 Questionnaire data.

189 Questionnaire data.

190 Gulu DHO.doc - 16:9 (33:33).

191 UCMB 2007.

192 Questionnaire data.

193 MoH.doc - 19 :35(25 :25)

194 Mukono DHO 2.doc - 24:14 (58:60).

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of concerns about current funding trends, the rigidity of funders regarding what their funds could be used for, and how they had to be accounted for, all factors that restrict PNFPs' capacity to act. Examples of these constraints included:

- Some donors overlook PNFPs.¹⁹⁵
- Government prioritises primary health care at the expense of curative services. "Cancer is completely left and the government takes it very clearly that they asked the private sector to help. But, I mean, poor people also get cancer. The rich can always afford."¹⁹⁶
- Funders prefer programmes that allow them to 'harvest outputs';¹⁹⁷ and tend to fund these outputs, but not the system that produces them.
- Recurrent costs for items like remuneration, salaries, running of water, electricity, fuel are excluded by many funders¹⁹⁸.
- It is difficult to find funders willing to support PNFPs HR costs to enable them to retain staff, and train more staff.
- Bigger facilities or more space is needed, e.g. for new ART programmes; crowding increases TB risk.¹⁹⁹ Yet infrastructure development and consumables are not funded.²⁰⁰
- Funding for admin costs needs to be more balanced; the 7% ceiling most funders impose is not sufficient.²⁰¹
- MDGs cannot be achieved if vaccines are not available, nor fridges to store them.²⁰²
- Transport is a major problem in rural areas; both affordable ambulance services for patients but also transport for staff to supervise facilities.²⁰³ In the context of overwhelming poverty, as in Gulu where 65% of the population live on less than one dollar a day, people cannot pay for transport to come to the health centre.²⁰⁴ In Mukono where a substantial part of the population lives on islands, the transport issue becomes even more vexing.
- No operational research is funded, nor conducted into the causes of the problems in the health service.²⁰⁵

6.7.3 THE SINGLE DISEASE FOCUS: AREAS OF PRIVILEGE IN A DESPERATE CONTEXT

Key informants highlighted several problems that resulted from funding designated for specific single disease responses, such as the Global Fund (see Box 6.6). For example, having funds so tightly specified made it impossible to make those funds available for disasters like the recent flooding in Uganda.²⁰⁶ In addition, having generously funded programmes within a system, even within one facility, resulted in situations where patients with the same complaint might receive a very different quality of treatment, because for one the complaint was AIDS-related, and for the other it was not.²⁰⁷ Further, on the system level the favoured status of AIDS programmes and their staff above the general health system that supported these programmes led to eventual collapse of both when the structures that made programmes function could no longer continue operating as resources got drawn away.²⁰⁸ Lastly, people with HIV or AIDS found support in many quarters; as these were not co-ordinated they often collected benefits from multiple services.²⁰⁹

Box 6.6 Impact of vertical programmes

For the IRCU, their bread and butter is the success of the project. If they fail to make the target, the project goes.

For us (UCMB) that's not the end of it. I mean for us it's the sustainability of the health unit that provides AIDS services along with all the other services. And we can't skew to transform a general hospital into an AIDS specialised hospital, because those guys dealing with AIDS patients get double the salary of the others because there, there is money and for the others there is no money.

So you have an area of privilege created inside institutions, that is the AIDS area, while the majority of the work of the institution is general care.

Source: UCMB.doc - 18:7 (19:21)

195 FGD Kampala 1.doc.

196 FGD Gulu.doc - 7:69 (179:180)

197 FGD Mukono.doc - 8:68 (188:188)

198 FGD Gulu.doc - 7:73 (188:188)

199 FGD Kampala 1.doc.

200 UNICEF.doc - 15:22 (36:36)

201 FGD Kampala 1.doc.

202 FGD Kampala 1.doc.

203 FGD Gulu.doc - 7:59 (152:153)

204 FGD Gulu.doc - 7:70 (180:180)

205 FGD Kampala 1.doc.

206 WHO.doc - 14:17 (134:138).

207 FGD Gulu.doc - 7:87 (217:217).

208 FGD Mukono.doc - 8:78 (209:209).

209 FGD Gulu.doc - 7:88 (217:217).

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6.7.4 SUSTAINABILITY AND CONTINUITY

The primary requirement for sustainability of health services was a stable source of resources. In the case of Uganda's PNFPs this was not a given, considering that its government was unable to commit itself, being itself dependent for 50% of its budget on donors whose policies back home could change.²¹⁰ Linked to this condition, informants mentioned two other requirements for sustainability:

- funding for development and expansion of infrastructure;²¹¹ and
- a reliable source of drugs.²¹²

An intriguing suggestion came from one respondent who pleaded for managers with the "capacity to negotiate with those who have the money to finance the health services"²¹³ and reinforce the fact that there were two partners in decisions around funding priorities, not one donor and one recipient. This echoed the strong plea we heard in Zambia for a consultative process around decision making for funding of health services.

6.7.5 WORKING IN CONTEXTS OF EXTREME POVERTY

A number of difficulties arise when providing health services in contexts of extreme poverty, unfortunately a common condition for PNFP facilities in Uganda. The problem was evident when patients came to a PNFP facility after having tried basic drugs elsewhere that had failed. They then needed a higher level of treatment, which was more expensive – and often unaffordable for both patient and facility.²¹⁴ Referrals were complicated by the lack of affordable transport, but even more so by the inability of people to provide meals for hospitalised relatives, especially when this involved travel as well.²¹⁵

The matron at Lacor hospital in Gulu told about a small dip in the number of outpatients when schools opened, as people who had already spent money to send children to school had nothing left for health expenses.²¹⁶ She was also concerned about patients who "run away from hospital", where they received free treatment, but needed to provide their own meals. Often their relatives were unable to provide them with regular meals or could not afford transport fees to bring the food, and so they abandoned their treatment and went home. In some cases, as in Lacor, the facility did provide food for malnourished patients and had a supply of food supplements or a dry ration for the most needy patients; but some who were in need of this did not feel free to discuss their need with staff and preferred to 'abscond'.²¹⁷ A similar problem occurred with patients who were on ART and needed support to be able to buy nutritious food in order to be able to take the drugs.²¹⁸

One way of responding to this problem was to create some sort of 'Samaritan Fund' to cater for such desperately poor clients, either to support them with nutrition or to make it possible to waive the user fees for them. It was then also necessary to have some criteria for awarding this support.²¹⁹ Additional subsidies or funding for staff salaries of PNFP units would free up their resources for lowering user fees and thus becoming more accessible to the most needy patients.²²⁰

6.8 KEY AREAS FOR POTENTIAL INVESTMENT

Key informants and other respondents involved in the study expressed strong support and made numerous pleas around funding, pointing out that what most needed to be funded was not a particular aspect of health care or vertical intervention, but *the health system* as such. The primary area of concern for most participants was the human resource needs.

210 MoH.doc - 19:29 (76:76).

211 Mukono DHO 1.doc - 23:44 (75:75).

212 FGD Gulu.doc - 7:60 (154:154).

213 UCMB.doc - 18:43 (80:80).

214 FGD Mukono.doc - 8:73 (204:204).

215 Mukono DHO 1.doc - 23:7 (14:14) & 23:8 (14:14).

216 FGD Gulu.doc - 7:83 (205:205).

217 FGD Gulu.doc - 7:92 (243:244) & 7:93 (249:249).

218 FGD Mukono.doc - 8:66 (184:184).

219 FGD Gulu.doc - 7:84 (206:207).

220 Mukono DHO 1.doc - 23:45 (76:76).

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6.8.1 HUMAN RESOURCE: "THE RESOURCE THAT TURNS OTHER RESOURCES INTO USEFUL MEANS"

If I were to advocate for funding for the PNFPs, I would look critically at the areas of staffing, and if there is a way that these donors can support staffing. Because what I see as very critical is that you may have everything on the ground: supplies, drugs, everything. But if the human resources for health are not paid much attention to, we are not likely to go very far. In other words it's the human resources that turn the other resources into useful means.²²¹

This was the area prominently highlighted by KIs and FGDs alike as the one crucial aspect of the health system that most needed funding, but which, ironically, seemed most definitely excluded by many potential donors and development partners. To attract and retain staff required funding for the following:

- salaries for qualified staff, commensurate to market rates
- benefits to include medical insurance, transport, secure retirement benefits
- care for carers for overworked, burnt-out staff
- incentives to attract professional staff to hard to reach areas, and
- provision of personal development opportunities for staff, e.g. sponsorship opportunities for further studies.

Many facilities were under-staffed and the staff members that were there were of lower cadres.²²² Capacity building was needed – and needed to be funded – in order to retain current staff and attract others. Specific funding requirements for training and capacity building included:

- support of health training schools, especially in remote areas
- training of specialists
- strengthening of management in the medical bureaux' networks
- IT skills for staff, especially staff in HMIS and stock control, and
- overall strategic planning, needs assessment and M & E.

6.8.2 INFRASTRUCTURE AND OPERATIONAL COSTS

Various areas of concern were noted that required support for the functionality of the health system as a whole:

- a reliable drug supply
- funds to replace outdated equipment
- reliable transport
- concerning the actual structures housing health facilities funding was required for own buildings, and additional space in lower-level facilities
- own laboratories and theatres, and
- staff quarters.

A further cluster of requirements concerned institutional support, i.e. funds for operational costs and to support networking structures.

6.8.4 SPECIFIC INTERVENTIONS

In addition to funding for those aspects of the health system as a whole, as mentioned above, funding was also needed for some specific needs. No specific vertical interventions were mentioned as requiring funding, although there were facilities that indicated that they would provide or scale up certain treatments if funding was available (See Section 6.3.1). Where specific needs were raised they concerned the impact of poverty as discussed above (See sect 6.7.5).

6.8.5 WHERE FUNDING SHOULD GO

It was clear that both government health services and those provided by religious entities were in need of additional funding to address the concerns raised here – and the growing needs of a growing population.²²³

Some respondents favoured the basket funding approach, where funds – even if intended to support PNFPs – would be channelled through the MoH and reach PNFPs through direct subsidies or via the districts. Such funding would encounter the difficulties sketched above (see Section 6.5.1). Not surprisingly, then, a majority of respondents considered

221 UNICEF.doc - 15:18 (32:32).

222 FGD Gulu.doc - 7:62 (158:160).

223 MoH.doc - 19:21 (52:52).

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direct funding through the Medical Bureaus as more efficient and reliable.²²⁴ At least one MoH official agreed that PNFP partners needed donor support and that this was best done directly.²²⁵ The only concern raised about direct funding was that the balance between funding big urban facilities and rural lower level units should be in favour of the latter.²²⁶ It was suggested that decisions about how to allocate funds should not be dictated to PNFPs,²²⁷ but should be negotiated in a genuine partnership.

6.9 RECOMMENDATIONS

*If you think that this is a precious asset for the country, that you want to maintain, not only you have to support it - but support it in a way that is conducive for the institution. Because you are not dealing with programmes. You are dealing with institutions.*²²⁸

- 1) It is recommended that government provide more certainty to the subsidy for the PNFP sector. Subsidies that had been received from government had been translated into lower user fees and hence better utilisation. But unless the subsidies were reliable, it was not possible for PNFPs to continue reducing their fees, as they had to consider the possibility of lower subsidies in the following round.
- 2) Parity in salaries between PNFP and public sector staff was needed if the PNFPs were to survive. Donors funding the state should use their power to ensure that their money was not used to harm a social sector that was so important for the country, by going into unilateral salary increases for MoH employees.
- 3) MNCR conditions were a great concern but improving services was expensive, as it required such a comprehensive infrastructure. The way in which PNFP facilities had used the little leeway they had with limited financial resources to make services more accessible for pregnancy-related needs, was much appreciated. Funding that would allow all facilities to provide these services free of charge would make a big difference to utilisation rates. Also, ensuring safe and reliable transport would make referrals for delivery complications to higher care units possible.
- 4) The 'invisibility' of congregation-based health initiatives did lead to their contribution being undervalued, also by potential funders. It was recommended that intermediaries be set up to co-ordinate these REs and strengthen their technical capacity, addressing local contexts and needs.
- 5) PNFP health training schools were an important contribution to the national health system, with 60% of nurses trained at RE facilities. This was an opportunity for imparting the ethos and values inherent in religious traditions to health care staff beyond the faith-based facilities. It did require at the very least an investment from the public institutions that would benefit by employing trainees (and by extension western governments that recruited health workers from Africa).
- 6) The study found an exemplary model of collaboration between all health providers at district level in Mukono, but could not identify the factors that made this possible. Studying this model (and others in different settings) in detail could yield insights necessary for its replication in Uganda and elsewhere.
- 7) It is important that the areas and extent of collaboration with TH be expanded and deepened. This applied to the state as much as to the PNFP sector. This would require representative association(s) of traditional healers in order to negotiate on behalf of the whole sector.

224 FGD Mukono.doc - 8:98 (291:291).

225 Mukono DHO 1.doc - 23:48 (81:81) & 23:51 (85:85).

226 Gulu DHO.doc - 16:21 (56:58).

227 WHO.doc - 14:17 (134:138).

228 UCMB.doc- 18:47 (87:88).

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