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# Is Religion Relevant in Health Care in Africa in the 21st Century?

Dr. Sam Orochi Orach
Executive Secretary
Uganda Catholic Medical Bureau

# Outline of Presentation

- Working definition of “Religion”
- Key Take-home Messages
- Brief History of Uganda’s Health System
- Lessons Learnt
- Conclusions
- Recommendations

# Definition

- “Religion” here as manifested through:
  - Entities whose primary purpose or that of the larger organisation they belong to is to nourish faith in God based on Scriptures.
  - Focus is on the fulfilment of scriptures by such entities through the works in health services

# 3 Key Take-home Messages

- Religious health services still very relevant in Africa
- Priority needs to be given to:
  - Strengthening of internal systems and coordination
  - Building and harnessing of partnerships
- Religious leaders need to take front seats at national and international partnerships and in advocacy

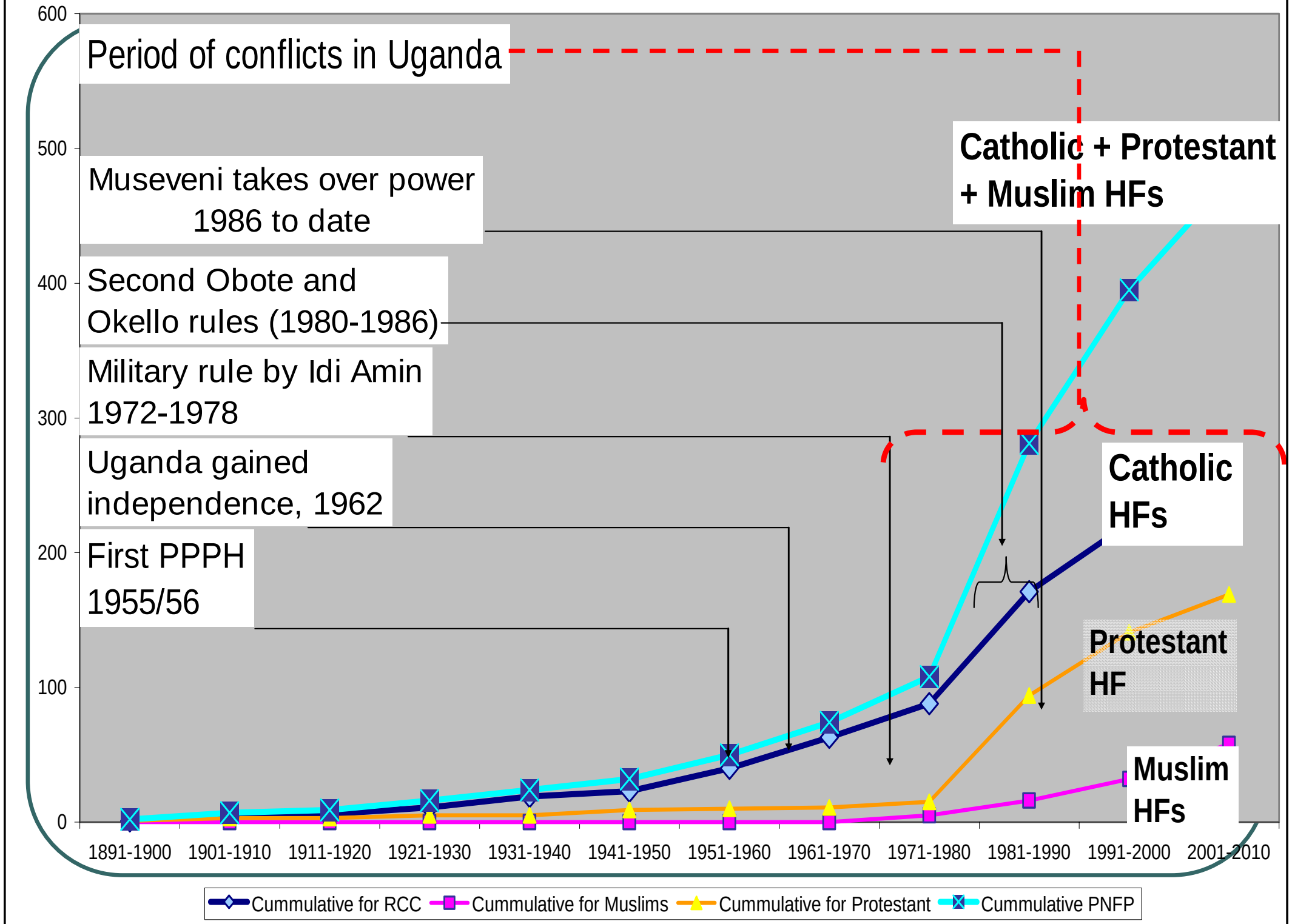
# Brief history health services in Uganda

# Religious bodies as pioneers and factors for resilience in health sector

- They founded health care around the world
- In Uganda:
  - 1897 Mengo hospital (Anglican)
  - 1899 Rubaga hospital (Catholic)
  - 1919: First Midwifery school – Mengo (Anglican)
  - 1919: First Nursing school – Nsambya (Catholic)

# Three Main Religious health networks

- Catholic – UCMB
- Protestant Churches – UPMB
- Muslim – UMMB
  - Separate but collaborating


Period of conflicts in Uganda
Museveni takes over power 1986 to date
Second Obote and Okello rules (1980-1986)
Military rule by Idi Amin 1972-1978
Uganda gained independence, 1962
First PPPH 1955/56
Catholic + Protestant + Muslim HFs
Catholic HFs
Protestant HF
Muslim HFs
600
500
400
300
200
100
0
1891-1900
1901-1910
1911-1920
1921-1930
1931-1940
1941-1950
1951-1960
1961-1970
1971-1980
1981-1990
1991-2000
2001-2010
Cummulative for RCC
Cummulative for Muslims
Cummulative for Protestant
Cummulative PNFP

- Informal Public-Religious or Public – FBO Partnership for health existed from the beginning.
- 1955: First formal P-FBO partnership
  - Gazetting of UCMB and UPMB as channels for Government grant-in-aid to religious health facilities
    - But Medical Bureaus themselves created much earlier (UCMB in 1936)

- Health systems collapsed beginning with dictatorial reign of Idi Amin (1972-1979)
- FBOs survived turbulence and filled a lot of gap
- Formal partnership reactivated in 1997/98
- 2000: PNFPs as part of Sector Wide Approach (SWAp)
  - (*75% being 3 religious health networks – Catholic, Protestants, Muslims*)

# The Partnership

- Is stronger / *formal* between Public-Facility-based PNFP/FBO.
- But the "*Formal*" partnership is really not "formal"
  - PPPH Policy yet to be passed by Cabinet (process has taken 8 years now)
  - No MoUs – Absence of policy makes it even more difficult for government to commit to MoUs
  - No Service Level Agreements (SLAs)

# The partnership

- PNFPs members of Health Policy Advisory Committee (HPAC) and its working groups
- Budget support to PNFP facilities – *(though dropping now)*
- Joint planning and monitoring

# Outcome

# 7 Areas of Outcome of the Partnership – To the Sector

1. Religious facilities / organisations as source of resilience to health services
   - Especially in moments of instability
   - 80% of PNFPs are in rural areas
2. Mutual learning
   - E.g. stronger functionality of HMIS in Faith-based networks
   - More efficiency in use of resources in FBO networks
3. Sharing of resources

# 7 Areas of Outcome of the Partnership – To the Sector

4. PNFPs (3 networks) contribute:
   - 39% of Uganda's 127 hospitals
   - 43% of hospital beds
   - 25% of lower level facilities (Clinics / health centres)
   - 11,200 health workers (Govt about 26,000)
   - 60% of schools training nurses and midwives
   - 30% of combined Public-PNFP outputs
   - 40% of patients on Antiretroviral treatment

# 7 Areas of Outcome of the Partnership – To the Sector

5. But None-facility based Religious health bodies not well documented in numbers and output
6. At least 16% of agencies doing HIV/AIDS work are faith-based (*AMREF 2001*)
7. About 60% of HIV prevention services are by faith-based (mainly non-facility based CSOs)

# RHAs still Relevant?

# Are Religious health services still relevant in 21st Century?

- More providers including the Private-Health-Providers ("*For-Profit sub-sector*")
- More macro-economic challenges to the religious approach to health services
- Heroism of religious bodies challenged
- But Government also unable to provide services single-handed

# Are Religious health facilities still relevant in 21st Century?

- Situations of instability continue to exist
- Mistrust of government health system worsening
  - Both citizens and donors
- Increasing accusations for inefficiency, poor work ethics and corruption against public systems
- Religious facilities and community-based programs seen as beacon of hope
  - Are easily identified with and acceptable to communities even in conflict

# Are Religious health facilities still relevant in 21st Century?

- Question if not “whether” but rather “How” religious bodies can sustain their roles in health in this century
- Having multiple players has been advantageous
  - Affected differently and respond differently to challenges or shocks / situations of difficulty
  - Different comparative advantages for the same goal

# 12 Lessons from Uganda

# Lessons

1. Religious health assets are key to the health sector in Africa (*both facilities and non-facilities*)
2. Working independently is no longer sustainable – not beneficial to communities, RHA and Govts.
3. Partnership (formal / informal) has characterised any success in Uganda's health system
4. Best thing to do is to strengthen that partnership

# Lessons

5. Alignment between RHAs and Public sector was responsible for the partnership
   - Shared vision, goals, objectives and outputs
   - Sitting together at the table of dialogue
     - Policy, Planning, distribution of resources, M&E etc
   - Recognition of the contribution of each partner
6. Visionary leadership important
   - Political
   - Religious leaders

# Lessons

7. Presence of strong coordinating and systems strengthening bodies important
   - Support for such **national bodies** is important
8. Absence of agreed legal framework weakens the partnership
   - Decisions depending on will of leaders as they come
   - Some unilateral government decisions undermined the Religious health networks / PNFPs

# Lessons

9. Strengthening only public system does not strengthen the sector
10. Deliberate strengthening of partners all is needed
    - Mutually done, mutually beneficial
    - Strengthen leadership and management of all

11. Pulling together (Inter-faith collaboration) provides a big strength
12. Functional Health management Information System is key to demonstration of relevance of Facility-based RHAs
    - Basis for advocacy

# 3 Conclusions

# Conclusions

1. Roles of RHA in health still very relevant in Africa
   - Both as providers and advocates
2. But workable partnership is important for sustainability
   - Intra-faith, Interfaith, with government, with other non-state actors and with Donors

- Strong internal cohesion is important

# Conclusions

3. The questioning of the relevance of RHAs is a threat to the whole health system in Africa
   - Religious bodies need to defend themselves and society against that threat
   - Informed advocacy must not be left only to technocrats
   - Religious leaders need to engage actively in the “political” advocacy

# 9 Recommendations

# Recommendations

1. Partnership is the way to go
2. But make partnerships that work
   - Avoid partnerships that are purely for convenience
   - Need shared / aligned vision, goals etc
   - Cultivate interest in one another
   - Accept one another for whom and what each is – no imposition of values, goals and objectives
   - Respect one another – do not undermine

# Recommendations

- Have mutually agreed, clear and fair expectations
  - Be ready to revisit expectations
- Work towards clear policies, MoUs and SLAs
  - Need simple cooperative agreements
- Partners need to be interested in sustainability of systems of one another for mutual benefit

# Recommendations

- Make effort to learn from one another
- Help weaker partner overcome weaknesses
- Avoid interventions that overwhelm or distort the partners' systems
- Encourage integration into existing systems of implementing partners
- Avoid the "Blame game"

# Recommendations

3. Strengthen systems especially governance, management and coordination
   - National networks and Implementing levels
4. Consolidation is top priority
5. Mutually align and learn
   - Sustainability of the Sector and Partners
6. RHA to build strong capacities for informed advocacy

# Recommendations

7. Strengthen inter-faith partnership
   - Greater advocacy and negotiation power



# Recommendations

8. Identify and work with allies
   - National and international
9. Raise the profile of Religious Health Assets onto Continental and World Agenda

# GOD BLESS