Senior Religious Leaders' Meeting
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Overview of FBO contribution to Uganda's health sector and overall national HIV/AIDS response

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Purpose of Presentation

- To create appreciation of the significant contribution of FBO to health and HIV/AIDS care in Uganda
- To explain why FBOs have to participate in health and HIV/AIDS care
- The importance of deliberately strengthening FBOs efforts for Health and HIV/AIDS care

Outline of Presentation

- Brief history of FBO involvement in health care in Uganda
- Brief history of Public-FBO partnership in health care in Uganda
- Contribution of FBOs to health care in Uganda
- Comparative Advantage of FBOs
- Advantages of Public-FBO partnership in health and HIV/AIDS services

History of FBO in Health care in Uganda

- FBOs introduced modern medicine into Uganda
- Bishop Tucker (Anglican) invited Dr. Albert Cook and Nursing Sister Katherine
- Dr. Albert Cook and Sr. Katherine arrived in Feb. 1897
  - Started work in Mengo on Feb. 22nd 1897
    - Before any other public health facility opened.
  - Rubaga opened in 1899
- Anglican and Catholic Churches remained big providers of health services both in facilities and in communities
- Joined by Muslims and other faiths

Public-FBO Partnership in health

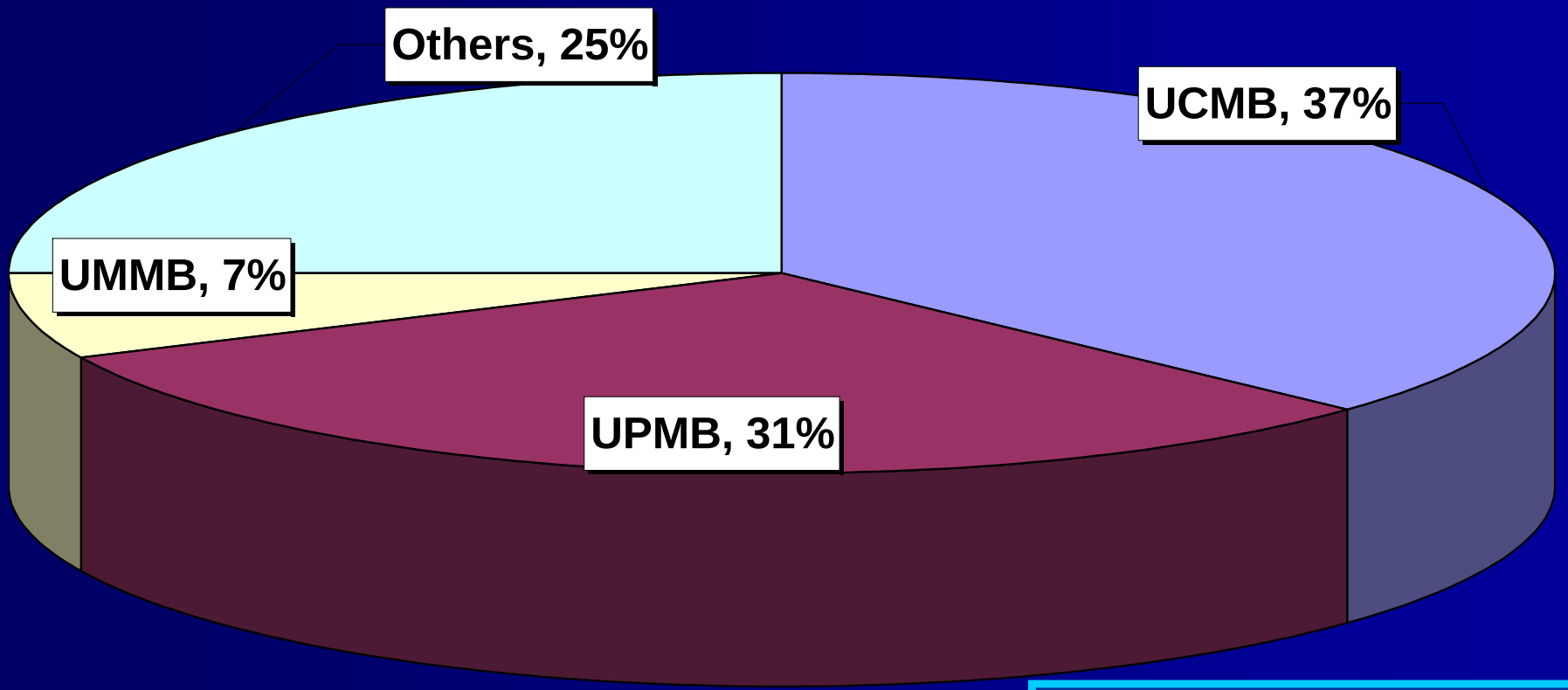
- Colonial government appreciated work of FBOs
- Decided to support them to complement government (*1954: The Frazer Commission recommendation*)
- 1955: Gazetting of UCMB and UPMB as channels for support to their networks
- 1986: Owor Commission recommended reactivation of Public-Private partnership

- 1996-1997: Discussions between UCMB + UPMB and government to avert crisis in the networks
- Agreed to call the FBO facilities PNFP
  - No distribution of surplus
  - Used to increase or improve services
- June 1997: Budget subsidy ear-marked for PNFPs
- 1999: PNFPs participated in launching of Sector-Wide Approach (SWAp)
- Agreeing to work as non-competitive partners
  - Same goals and objectives – providing quality affordable services to the poor

- Under SWAp:
  - FBO health networks are part of the Health Policy Advisory Committee (HPAC)
  - Supposed to participate in planning at the different levels (Central, districts, HSD and facilities)
  - JMS supports government efforts in procurement and delivery of medicines and medical supplies
    - Has earned a lot of credibility and integrity so far

Facility-based PNFP

FBO Health facilities outside UPMB+UMMB+UCMB are few but would increase the count



The **"Others"** also include some Private hospitals listed as "PNFP"

UCMB+UPMB+UMMB =75% of "PNFP"

Contribution of the PNFP (UMMB+UPMB+UCMB)

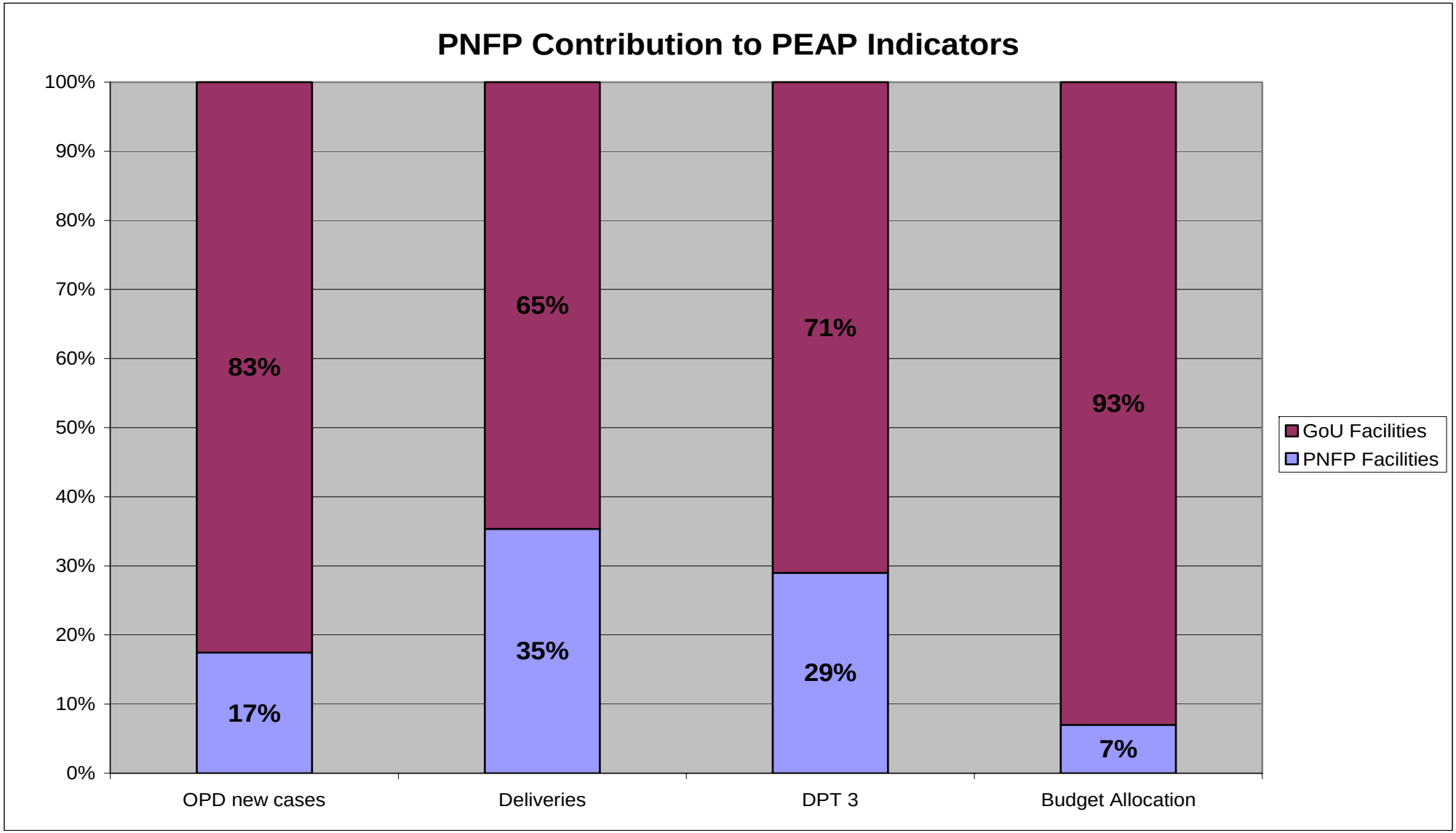
- Over 40% of hospitals
- About 25% of lower level facilities
- 75% of nurses + midwifery training schools
- Majority are in rural poor areas – reaching the poor
- 30% of combined Public - UMMB+UPMB+UCMB health workforce
- Back bone for resilience in health care in conflict zones especially north, north-east and East.

HOSPITAL BEDS IN UGANDA AS OF JUNE 2007

HOSPITAL BEDS	Beds	%
Govt (Incl National and RR Hospitals	9,448	52%
PNFP	**7,882**	**43%**
Institutional	175	1%
Private	712	4%
Total	18,217	100%

Source: MoH, Clinical Services

What UCMB+UPMB+UMMB contribute to the Public-PNFP Health Sector Output (HSSP II)



- ART is provided by:
  - All 27 hospitals in the UCMB network,
  - 11 out of 16 hospital in the UPMB and
  - 2 out of 6 in the UMMB networks.
  - HC IVs and a few Lower level facilities e.g. Reachout Mbuya
- Total enrolment onto ART in the UCMB network alone grew from 759 by mid 2004 to over 12,000 by June 2007[1].
- Other HIV/AIDS related services provided at all levels

[1] Data received by UCMB from its network facilities

- Creation of Inter-religious Council of Uganda
  - Part of interest is HIV/AIDS service provision
- But FBO facilities are also involved in control and prevention of malaria and TB activities
- Higher contribution in rural areas and areas of conflict
- Especially in the more costly areas like surgery, delivery

Contribution by non-facility-based FBOs

- Mainly as CBOs / NGOs
- Not visible because their outputs are taken up and attributed to donors
- Not mapped out
- Remarkable contribution mainly to prevention and mitigation

Comparative advantage of FBOs

1. Belonging to and acceptability by the community
   - Credible in the eyes of the community – appeals to their values
2. Some level of resilience:
   - Presence of strong PNFP provided alternative that could survive situations of conflict or political unrest / crises
     - Back bone to health care during Amin era
     - Also the back bone of health care in the prolonged war in northern Uganda
   - Different organisations react differently to situations of shock
   - Better to have multiplicity and options

3. Allows for mutual learning and increases arena for innovations that benefit the system
4. Flexibility in responding to new needs where beurocracy might make it difficult e.g. recent ebola epidemic
5. Able to reach the grass-root areas better (esp. the non-facility based PNFP)

In summary

- FBOs have the longest history of providing health care in Uganda
- FBOs have provided credible partnership to government in providing Health and HIV/AIDS services in Uganda
- Government gets value for the money it gives to FBO facilities / organisations

In summary

- Contribution of non-facility-based FBO providers is significant but needs attribution from the collective reports
- Participation of FBOs in health and HIV/AIDS is both a compliance with Scriptures and a democratic process that aligns with policy of decentralisation
  - Otherwise known as principle of subsidiarity
- Investing in strengthening the FBOs for health and HIV/AIDS services should be in the interest of every right-intentioned Ugandan

END

THANKS FOR LISTENING